Simply Sleep

Please Fax completed order form to (346) 443-2398

Patient Name:_____ **DOB:** _____

PLEASE ATTACH: □ **DEMOGRAPHIC SHEET** □ **HISTORY & PHYSICAL**

Study Ordered:

□ **Home Sleep Test up to Three Nights**
CPT: 95800, 95806, G0398, G0399, G0400

____ 1 night ____ 2 nights ____ 3 nights

Please Include:

Height:_____ **Weight:**_____

BMI: _____

Neck Circumference: _____

Epworth Score: ____

Diagnosis:

- □ Obstructive Sleep Apnea
- □ Insomnia
- □ Narcolepsy
- □ Excessive Daytime Sleepiness
- □ REM Behavior Disorder
- □ Periodic Limb Movement Disorder
- □ Involuntary Movements
- □ Restless Legs

Comorbid Medical Conditions:

- □ Cognitive Impairment
- □ Neuromuscular Disorder
- □ Stroke/TIA
- □ Seizure Disorder
- □ Epilepsy
- □ Altered Mental Status
- □ Optic Neuropathy
- □ Fibromyalgia
- □ COPD/Asthma
- □ Hypertension
- □ Congestive Heart Failure
- □ Heart Disease
- □ Atrial Fibrillation
- □ Morbid Obesity
- □ Diabetes
- □ Other:

Physician Signature **Date**

Physician Address **City** **State** **Zip**

Physician Phone ( ) **Physician Fax ( )** **Faxed By (employee)**