



**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)**

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