HomeSleepDelivered.com
P: (877) 270-7587

Home Sleep Test Order Form

Provider: Please complete this form and **FAX** with **OFFICE NOTES & SLEEP EPWORTH EXAM** to

337-857-3514

Patient Demographics

Name _____Gender _____ DOB ___/__/_____SSN_____

Address _____City_____St_____Zip_____

Main Phone (_____)_____ Alt. Phone (_____)_____

Insurance

Payer 1 _____ ID# _____ Group #_____

Payer 2 _____ ID# _____ Group #_____

Referring Provider

Name _____ NPI_____

Address _____City_____St_____Zip_____

Main Phone (_____)_____ Fax (____)_____

Diagnosis		Symptoms			
OSA	☐	Snoring	☐	Hypertension	☐
Excessive Daytime Sleepiness	☐	Observed Apnea	☐	Hypoxemia	☐
Unspecified Sleep Apnea	☐	Disturbed/Restless Sleep	☐	Non-restorative Sleep	☐
Insomnia with OSA	☐	Awakening choking or gasping	☐	Depression or Mood Disorder	☐
Ht _____Wt_____		Morning dry mouth or headache	☐	Obesity	☐
BMI _____					

Procedure

Home Sleep Test: 2 night Level III, CPT G0399 (Record respiratory airflow, respiratory effort, O2 saturation and heart rate)

Test on: "On Room Air" unless following is checked: ☐ On current Oxygen RX

☐ Other _____

STAMPS NOT VALID

I am the patient's treating physician and I have filled out this prescription based upon a face to face office visit. I am ordering this test to determine if my patient has OSA.

Physician Signature: _____ Date:_____

(Dr./PA/NP Only)

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Sleep Epworth Exam

This questionnaire is a first step in determining whether you may have Sleep Apnea

First name: _____ Last Name:_____

Date-of-birth: _____/_____/_____Gender: ☐ Male ☐ Female

Email:_____

Instructions: Enter a number in each box according to the scale below. If you don't participate in some of these activities, use your best guess.

How likely are you to fall asleep in the following situations? 0=Never 1=Slight chance 2=Moderate chance 3=High chance	Enter Score (0-3)
Sitting & reading	
Watching TV	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car stopped for a few minutes in traffic (while you are the driver)	
Add your entries to arrive at your TOTAL score	

Next Step

For scores above 9, we recommend you consult with your physician to determine if a home sleep test is the right step for you. Take this questionnaire along with the attached order form to your physician appointment.

What does your score mean?

0-9: Normal
10-12: Borderline
13+: Abnormal