Home Sleep DELIVERED

REV 10/2018

Phone: 877-270-7587 Fax: 337-857-3514
or 337-210-2093

FACE TO FACE- Home Sleep Exam Order Form

Patient Demographics:

Name: _____ Sex: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ EMAIL: _____

Additional Phone: _____

Primary Insurance: _____ ID#: _____ Group #: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Referring Physician Demographics:

Physician Name: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

★ ***Diagnosis:**

- ☐ Obstructive Sleep Apnea (i.e. to confirm suspicion)
- ☐ Excessive Daytime Sleepiness
- ☐ Unspecified Sleep Apnea
- ☐ Insomnia with OSA
- ☐ Hypertension
- ☐ Depression or Mood Disorders

***Symptoms:**

- ☐ Snoring
- ☐ Observed Apnea
- ☐ Disturbed or Restless Sleep
- ☐ Awakening choking or gasping
- ☐ Morning dry mouth or headache
- ☐ Obesity
- ☐ Non-restorative Sleep

★ **Height:**_____ **Weight:**_____ **BMI:**_____

PLEASE FAX PROGRESS NOTES DOCUMENTING SLEEP RELATED ISSUES

★ ***Procedure:**

Home Sleep Test: 2 night Level III, CPT G0399 ***(Records: 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 pt has OSA.

Physician Signature:_____ **Date:**_____

Doctor/PA/NP only