

Home Sleep Test Order Form

FAX to: **844-242-9966**

ALL FIELDS MUST BE COMPLETED



Patient Demographics:

Name: _____ M F DOB: _____ | _____ | _____ SS#: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone#: _____ Email Address: _____ Height: _____ Weight: _____ Neck Size: _____
Cell Phone # _____ *Receives Texts* Special Needs: _____

EPWORTH SCORE _____

Signs and Symptoms:

Please check all that apply or attach MSL Patient Screening Form

- Observed Apneas**
- Habitual Snoring, or, gasping/choking episodes associated with awakenings**
- Excessive daytime sleepiness (ESS) evidenced by:**
ESS >10, or Inappropriate daytime napping (*while driving, eating*), or Sleepiness that interferes with daily activities
- Unexplained Hypertension**
- Soft tissue abnormalities or neuromuscular diseases involving craniofacial area/upper airway**
- Obesity with a BMI > 30**
- Mood Disorders**
- Morning Headaches**

Please check all that apply:

- Previous cerebral accident more than one month ago
- Diabetes
- Low Functioning Thyroid
- Transient Ischemic Attack (TIA)
- Coronary Artery Disease (CAD)
- Sustained supraventricular tachycardic arrhythmias
- Sustained supraventricular bradycardic arrhythmias
- Ventricular fibrillation
- Sustained ventricular tachycardia
- Severe Congestive Heart Failure (NYHA class III or IV)
- Moderate Severe Chronic Obstructive Pulmonary Disease (COPD)
- Oxygen dependent for any reason
- Cognitive impairment (*unable to follow simple instructions*)
- Neuromuscular impairment; needs assistance for activities or daily living (ADLs)
- The patient is 18 years old or younger

ATTACH COPY OF INSURANCE CARD (FRONT AND BACK) AND APPLICABLE OFFICE NOTES



Test Ordered: **Multi-night Sleep Study to rule out OSA** *Equipment satisfies portable testing requirements and includes oximetry and body position, able to distinguish central from obstructive events.*

Oral Appliance Titration settings: Night 1 _____ Night 2 _____ Night 3 _____

Suspected Diagnosis: G47.33 Obstructive Sleep Apnea (*must be checked*)

Referring Physician Demographics:

Physician Name: _____ NPI: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Physician Signature: _____ **Date:** _____

I am the patients treating physician and I have ordered this prescription based upon a face to face office visit. I am ordering this test to determine if my pt has OSA