Home Sleep Test Order Form

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

ALL FIELDS MUST BE COMPLETED

MILLENNIUM SleepLAB℠
MSLatHome.com Testing At Home

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

Rx

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*_____

Diagnosis indicated by symptoms: ☐ **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

Phone: (877) 933-9470