DROPSHIP ONLY

Do not use if you dispensed a recorder from office

FAX form to: 847-465-3401

HOME SLEEP TEST REFERRAL/ORDER

PATIENT NAME:		**DOB:**	**Preferred Phone: ( )**	
Address:		City:	State:	Zip:
Height:	Weight:	Neck Size:	Gender:	

MEDICAL ORDER (This section outlined in **BOLD** may be replaced by an *approved* Electronic Medical Order)

Provider Name:	Address:	
Name of Practice:	City:	
Phone:	State:	Zip:
Fax [to send patient test results:	E-mail:	

By signing below, I attest that based on my examination of the patient and his/her medical history, there is a high probability of Obstructive Sleep Apnea. An unattended, type 3, Home Sleep Test with a minimum of 4 channels (airflow, respiratory effort, SpO2 saturation and heart rate), is medically necessary. No co-morbid conditions including, but not limited to, moderate to severe COPD, CHF, OHS, neurodegenerative disorder or cognitive impairment are present that prevent the patient from home sleep testing.

Test Ordered: Type 3, unattended home sleep test for up to 3 nights or other ____
ICD-10 code: Default to G47.30 or Other code: _______
CPT code: G0399, 95806 or 95800

Provider Signature: ___________________ **Date of Order: ___________** PLEASE SIGN & DATE

Patient Clinical Indication and Medical History Details (check all that apply for the Patient)

- ☐ Witnessed apnea events during sleep greater than 10 seconds in duration
- ☐ Excessive Daytime Sleepiness
- ☐ Atrial Fibrillation (AFIB)
- ☐ Disruptive Snoring
- ☐ Hypertension / High Blood Pressure
- ☐ Non-restorative, disturbed or restless sleep
- ☐ Gasping / Choking
- ☐ Daytime Fatigue

Complete this section ONLY if Re-testing the Patient **Prior DX of Apnea?** ☐ No ☐ Yes (if yes, Test Date: ______)

A new sleep test is indicated due to (check all that apply):

☐ Weight gain or loss (> 10% or BMI > 5) ☐ Evaluate therapy effectiveness ☐ Evaluate need to continue therapy

Is the test: ☐ Pre or ☐ Post treatment? **Indicate Type of Treatment:** ☐ Surgery ☐ Oral Appliance ☐ PAP ☐ Other

Patient's Primary / Secondary Insurance	**Name of Insured (*if not patient*):**	
Primary Insurance Name:	Group #	ID #
Secondary Insurance Name:	Group #	ID #

Send Snap Test Report to DME? ☐ Yes DME Name: Fax: (   )