SLEEP TECH LLC
847-778-2749
SLEEPTECH007@gmail.com

HOME SLEEP TEST ORDER FORM

Prescription and Statement of Medical Necessity

Prescriber Information

Provider Name: Phone: Fax:

Primary Contact: NPI:

Patient Information

Patient Name: (Last) (First) (MI) Sex: M☐ F☐

(Include apartment #. Unable to deliver to a P.O. Box)
Address:

City: State: Zip Code:

Cell Phone: _____ Email: _____ DOB: _____

Secondary Contact*: **Secondary Phone:** Height: Weight:

Sleep History & Physical: Must select all that apply

- ☐ Disruptive snoring
- ☐ Disturbed or restless sleep
- ☐ Non-restorative sleep
- ☐ Witnessed apnea event during sleep
- ☐ Choking during sleep
- ☐ Gasping during sleep
- ☐ BMI >30
- ☐ Frequent unexplained arousals from sleep
- ☐ Excessive daytime sleepiness (EDS) as evidenced by an Epworth Sleepiness Scale > 10 (ESS)

Suspected Diagnosis (ICD-10):

- ☐ Other _____
- ☐ Obstructive sleep apnea (G47.33)
- ☐ Unspecified apnea (G47.30)
- ☐ Hypersomnia (G47.10)
- ☐ Assessment of Efficacy of Surgery

Does Patient have: ☐ CHF? Severity: ☐ Mild ☐ Moderate ☐ Severe
☐ COPD? Severity ☐ Mild ☐ Moderate ☐ Severe

☐ Patient requests **self-payment of $250 OR:**

Primary Plan: Subscriber ID: Policy Holder Name: Policy Holder DOB:

Secondary Plan: Subscriber ID: Policy Holder Name: Policy Holder DOB:

Diagnostic Service Ordered ☐ Home Sleep Test (Type III) ☐ Oral Appliance Efficacy

Durable Medical Equipment (DME) Provider & Release of Test Results: Provider has patient consent to direct positive test results to the DME provider below for purposes of treatment of the patient. Patient has been advised of their freedom of choice in selecting DME.

DME Name: Phone#: Fax #:

Physician Signature_____ **Date**_____

I certify that above home sleep test is medically indicated and is reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

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