

**Patient Information**

Patient Name: \_\_\_\_\_  Male  Female DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

Primary Ins:  Medicare  Commercial Plan: \_\_\_\_\_ ID #: \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ ID #: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ FT \_\_\_\_\_ IN Neck Circumference: \_\_\_\_\_ IN BMI: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ NPI: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Local DME Supplier: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Face-to-Face Clinical Exam: Required to be documented in patient's medical record.**

Sleep History & Symptoms: **(Check ALL that are applicable)**

- Snoring  Daytime Sleepiness  Observed Apneas  Choking or Gasping during Sleep  Morning Headaches  
 Tired/Fatigued  Other (Describe Nature): \_\_\_\_\_

Focused CardioPulmonary & Upper Airway Evaluation: **(Check ALL that are applicable)**

- Large Tongue  Enlarged Tonsils  Large Uvula  Overbite  Under bite  Crowded Oropharynx  
 Worn Teeth  Nasal Obstruction  Hypertension  Obesity  Other (Describe Nature): \_\_\_\_\_

Epworth Sleepiness Scale: **How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?**

- 0 – **NO** chance of dozing      1 – **SLIGHT** chance of dozing      2 – **MODERATE** chance of dozing      3 – **HIGH** chance of dozing
- \_\_\_\_ Sitting & Reading      \_\_\_\_ In car stopped in traffic for few mins.      \_\_\_\_ Sitting inactive in public      \_\_\_\_ Lying down to rest in afternoon  
 \_\_\_\_ Watching TV      \_\_\_\_ Passenger in Car for hour w/o break      \_\_\_\_ Sitting quietly after lunch w/o alcohol      \_\_\_\_ Sitting & Talking

Epworth Score: \_\_\_\_\_ **(Normal Epworth Score is considered below 8)**

**Prescription for Diagnostic Procedure**

Diagnosis: **(At least one to be checked)**

- 780.57 – Unspecified Sleep Apnea       327.23 – Obstructive Sleep Apnea       780.51 – Insomnia w/ Sleep Apnea  
 780.53 – Hypersomnia w/ Sleep Apnea       799.02 – Hypoxemia       Other: \_\_\_\_\_

Home Sleep Test:  G0399 Type III Portable Monitor, minimum of four channels or G0398 Type II Portable Monitor, minimum of seven channels

- Room Air       Current Oxygen Prescription ( \_\_\_\_\_ LPM)       One Night Study       Two Night Study

**Physician Certification** I, the undersigned, certify that I have completed the requirements according to CMS guidelines prior to ordering this Home Sleep Test for the patient noted above. I further agree that this order is not for screening purposes of an asymptomatic patient and understand that CMS coverage guidelines require a **face – to – face evaluation**, relating to section three above, must be documented in the patient's medical chart prior to a HST is ordered. **By signing below, I find that it is medically necessary to have this Home Sleep Test completed.**

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**FAX COMPLETED FORM WITH INSURANCE CARD(S) TO ADSI AT (352) 274-9122**