HOME SLEEP TEST ORDER FORM

Prescription and Statement of Medical Necessity

Prescriber Information			
Physician Name:	Physician Email:		
Practice Name:		Practice Type:	
Address:	City:	State:	Zip:
Phone:	Fax:	NPI#:	
Primary Contact:	Primary Contact Email:		

Patient Information			
Patient Name: (Last)	(First)		(MI)
Address:	City:	State:	Zip:
Primary Phone:	Alternate Phone:	DOB:	
Sex: M ☐ F ☐	Email:	Patient ID#:	

Sleep History & Physical: Must select at least one

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

Diagnosis (ICD-9):

- ☐ Obstructive sleep apnea (327.23)
- ☐ Organic hypersomnia (327.10)
- ☐ Idiopathic hypersomnia w/ long sleep time (327.11)
- ☐ Idiopathic hypersomnia w/o long sleep time (327.12)
- ☐ Recurrent hypersomnia (327.13)
- ☐ Other organic hypersomnia (327.19)
- ☐ Other organic sleep apnea (327.29)
- ☐ Insomnia w/ sleep apnea, unspecified (780.51)
- ☐ Hypersomnia w/ sleep apnea, unspecified (780.53)
- ☐ Hypersomnia, unspecified (780.54)
- ☐ Unspecified sleep apnea (780.57)
- ☐ Other _____

Diagnostic Service Ordered ☐ Home Sleep Test ☐ 1 night ☐ 2 nights

☐ **Please include a therapy prescription form for the patient with the sleep study report.**

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.