Reset All Fields

Physician's Order for Home Sleep Test

The Complete Sleep Program
P.O. Box 161020, Salt Lake City, UT 84116 • (833) 878-2727

Fax Completed Form to (801) 595-2051

1 PATIENT INFORMATION

Local Treatment Supplier: 233107

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Cell: (_____) _____

DOB: _____ /_____ /_____ ☐ Male ☐ Female Height: _____ Weight: _____

Email Address: _____

INSURANCE

Employer: _____

Insurance ID #: _____ Attach copy of insurance card if available.

2 ORDERING PHYSICIAN

NPI: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (REQUIRED)

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) - _____ Fax: (_____) - _____

3 HOME SLEEP TEST PROCEDURE

Unattended, Type III Portable Recorder: measures blood oxygen saturation (SpO2), pulse rate, airflow, snoring levels, head movement, and head position to detect apnea and hypopnea events (CPT 95800).

Please indicate which of the following apply:

☐ On Room Air

☐ Test with Mandibular Repositioning Device (MRD) ☐ Reevaluate for Presence of Ongoing Sleep Apnea

4 DIAGNOSIS (MUST BE CHECKED)

☐ **G47.33**: Obstructive Sleep Apnea ☐ **Other ICD-10**: __ __ __ . __ __ Description:

I, the undersigned, certify that by signing below that I am ordering a Home Sleep Test for patient listed above. I certify that this order is not for screening purposes for an asymptomatic patient.

Physician Signature: _____ Date: _____ /_____ /_____

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