Home Sleep Testing Order Form

PATIENT INFORMATION			
Name:		DOB:	Gender:
Address:	City:	State:	Zip:
Email:		Work:	Cell:
Height:		Weight:	

PHYSICIAN INFORMATION			
Name:		NPI:	
Address:	City:	State:	Zip:
Email:		Phone:	Fax:

INSURANCE INFORMATION	
Name:	Policy #:

DIAGNOSIS (*Choose 1 suspected DX code below)*	**SIGNS & SYMPTOMS** (*Choose 2 boxes below)*
☐ G47.33 Obstructive Sleep Apnea (OSA) ☐ G47.30 Sleep Apnea, Unspecified Other ICD-10:	*List at least two of the symptoms below.* ☐ Chronic Snoring ☐ Witnessed Apnea ☐ Morning Headaches ☐ Excessive Daytime Sleepiness ☐ Unexplained Hypertension ☐ Efficacy of Surgery/Previous DX of OSA

HST TEST ORDERED

☐ Home Sleep Test - Type III – one night unattended (*Records Airflow, Respiratory Effort, Pulse, O2 Saturation)* on room air.

☐ Check here if the test is to be performed with the patient on current oxygen prescription.

PHYSICIAN SIGNATURE (*A stamped signature is not considered a valid order)*

I am ordering a Home Sleep Test for the patient listed above. I certify this patient was evaluated during an office visit and demonstrated sign and symptoms consistent with Obstructive Sleep Apnea. A Home Sleep Test is medically necessary and no co-morbid conditions are present. I further attest the evaluation was documented in the patient's chart notes prior to ordering this test.

Physician Signature:_______________________________________ Date:_________________________

PLEASE ATTACH TO THE PATIENT'S TEST FILE BY LOGGING INTO YOUR ACCOUNT AT VITALISTICS.COM OR YOU CAN FAX THIS FORM TO: (844) 550-9971

QUESTIONS CALL: 844-550-9970