



Home Sleep Apnea Testing Order Form
 Accredited by the American Academy of Sleep Medicine
 Phone: (215) 370-8116 Fax: (215) 360-3606
 www.somnotrek.com

Please complete the following and **SUBMIT VIA FAX** to (215) 360-3606.

DATE: _____

PATIENT INFORMATION			
Last Name:	First Name:	DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Address:		City:	State: Zip:
Social Security #:	Home Phone:	Cell/Other Phone:	

INSURANCE INFORMATION			
Primary Plan	Subscriber ID	Policy Holder Name	Policy Holder DOB
Secondary Plan	Subscriber ID	Policy Holder Name	Policy Holder DOB

Section 1: DIAGNOSIS	
<input type="checkbox"/> Sleep Apnea, Unspecified – G47.30	<input type="checkbox"/> Obstructive Sleep Apnea – G47.33
<input type="checkbox"/> Other:	

Section 2: SLEEP STUDY PRESCRIBED
<input type="checkbox"/> Home Sleep Apnea Test (HSAT) – G0399/95806

Section 3: SIGNS and SYMPTOMS OF SLEEP APNEA		
<input type="checkbox"/> Witnessed Apnea	<input type="checkbox"/> Gasping or Choking at Night	<input type="checkbox"/> Disruptive Snoring
<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/> Morning Headaches	<input type="checkbox"/> Non-Restorative Sleep
<input type="checkbox"/> Previously Diagnosed Sleep Apnea	<input type="checkbox"/> Test with Oral Appliance	
<input type="checkbox"/> Other (Specify):		
Enter Epworth Sleepiness Scale Score (Range 0 – 24; ≥ 10 = High Risk):		

I WOULD LIKE SOMNOTREK TO ORDER APAP/CPAP/BiPAP AND DME FOR THIS PATIENT IF INDICATED BY TEST RESULTS.

ORDERING PROVIDER INFORMATION			
Ordering Provider Name	Phone	Fax	NPI
Address:		City:	State: Zip:
Office Contact Name:		Phone # (include extension):	

ACKNOWLEDGEMENT
By signing below, I attest that I have examined this patient for the signs and symptoms of sleep apnea and find a Home Sleep Apnea Test is appropriate for this patient due to the high probability of sleep apnea. There are no co-morbid medical conditions that exclude patient from undergoing a Home Sleep Apnea test.
Physician Signature: _____ Date: _____
<i>(No Stamped Signatures Accepted)</i>

PLEASE FAX THE FOLLOWING TO (215) 360-3606:
<input type="checkbox"/> This Rx <input type="checkbox"/> H&P or Recent office note <input type="checkbox"/> Insurance Card <input type="checkbox"/> Patient's Demographics