Home Sleep Apnea Testing Order Form

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:** ☐ M ☐ 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	
☐ Sleep Apnea, Unspecified – G47.30	☐ Obstructive Sleep Apnea – G47.33
☐ Other:	

Section 2: SLEEP STUDY PRESCRIBED
■ Home Sleep Apnea Test (HSAT) – G0399/95806

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

PATIENTS CAN NOT UNDERGO HOME SLEEP APNEA TESTING IF USING NOCTURNAL SUPPLEMENTAL OXYGEN, CPAP/BIPAP THERAPY

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:** _____

(No Stamped Signatures Accepted)

PLEASE FAX THE FOLLOWING TO (215) 360-3606:

☐ **This Rx** ☐ **H&P or Recent office note** ☐ **Insurance Card** ☐ **Patient's Demographics**