Home Sleep Test Order Form

IDTF: Instant Diagnostic Systems, a division of VirtuOx, Inc
www.instantdiagnostic.com

Instant Diagnostic Systems™
A Division of VirtuOx

Rev: 10/9/2018

1 Patient Information: *Indicates required fields.

*Last Name: _____ *First: _____

*Phone: (____) _____ Alt. Phone: (____) _____ Language:_____

*Date of Birth: _____ *mm/dd/yyyy ☐ Male ☐ Female *Height:_____in *Wt:_____lbs

Address: _____

City: _____ State:_____ Zip: _____

Emergency Contact Name:_____ Emergency Phone:(____) _____

2 Insurance: Complete below or attach copy of insurance or patient face sheet

Payer:	Policy No:	Group No:

☐ Patient Is Self-Pay

3 Home Sleep Test: *Unattended Type III Portable Monitor*

☐ Comprehensive Home Sleep Test w Sleep Stages*	☐ Home Sleep Test On Room Air	☐ Home Sleep Test On Oxygen LPM _____	☐ Home Sleep Test On PAP Fixed Pressure / No Auto Pressure: _____	☐ Home Sleep Test On Oral Appliance	☐ Home Sleep Test with DOT certification	☐ Home Sleep Test for Pediatric Age 12-17

**Sleep Stages to be calculated by EMG, EOG, EEG. CPT 95827 and is performed separately from Home Sleep Test via 2-nights with insurance coverage.*

4 Diagnosis**:

☐ **Obstructive Sleep Apnea G47.33** ☐ **Sleep Apnea, Unspecified G47.30**

**A DIAGNOSIS IS REQUIRED NOTE: Many payors require OSA diagnosis (suspected or otherwise) for coverage

5 Medical History: *Complete and/or attach supporting chart notes. Symptoms required by many payers for authorization.

SYMPTOMS/MARKERS: Check ALL that apply. Some payors require 2 and up to 4 to determine medical necessity for coverage.

- ☐ Observed Apneas
- ☐ Daytime Sleepiness
  Epworth Score: _____
- ☐ Habitual/Disruptive Snoring
- ☐ Non-Restorative Sleep
- ☐ Obesity (BMI > 30)
- ☐ Hypertension, Uncontrolled
- ☐ Choking/Gasping during sleep
- ☐ Inappropriate napping
- ☐ Morning Headaches
- ☐ Craniofacial or upper airway soft tissue abnormalities
- ☐ Large Neck (>17" M, 16" F)

COMORBID CONDITIONS: Check all that apply

- ☐ COPD - Mod to Severe
- ☐ CHF (NYHA class III or IV)
- ☐ Recent stroke or TIA (last 30-days)
- ☐ Neuro-degenerative disorder/weakness
- ☐ Significant, persistent cardiac arrhythmia
- ☐ Obesity hypoventilation syndrome
- ☐ Chronic Opiate Narcotic Use

- None checked denotes none present

OTHER SUSPECTED SLEEP DISORDERS:

- ☐ Narcolepsy
- ☐ Nocturnal seizures
- ☐ Central Sleep Apnea
- ☐ Hyper or Parasomnias
- ☐ Restless Leg (PLMD)
- ☐ Insomnia

6 Ordering Physician Info & Signature * Indicates required fields

*NPI: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (**PHYSICIAN'S INDIVIDUAL NPI REQUIRED!!! Physician/PA/NP only)

*Last Name, First Name:

Address, City, State, Zip:

*Fax, Phone:

I, the undersigned, authorize Instant Diagnostic Systems to perform a Home Sleep Apnea Test on above patient. I certify that I am the physician identified on this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify that this order is not for screening an asymptomatic patient and that CMS coverage requires a prior face-to-face encounter with documented symptoms of Obstructive Sleep Apnea. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. The patient's medical record contains supporting documentation that substantiates medical necessity of the prescribed testing and the physician notes and other supporting documentation will be provided to Instant Diagnostic Systems upon request. I understand any falsification, omission, or concealment of material fact in any section may subject me to civil or criminal liability. A copy of this order will be retained as part of the medical record.

Sign Here: X _____ Date: ___/___/_____

Stamped Signatures Not Accepted

mm/dd/yyyy