Medical Diagnostic Solutions

Sleep Testing and Interpretation Services

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EVALUATION AND PRESCRIPTION FOR HOME SLEEP TEST

PATIENT: ______________________________ **DOB**: ____________ **Last 4 SSN:** ___________ **Phone:** ______________

DOCTOR: ______________________________ **NPI:** ______________ **Fax:** ________________**Phone:** ______________

MEDICAL NECESSITY FOR HOME SLEEP TEST

THE PATIENT HAS ANSWERED POSITIVE OR IS KNOWN TO HAVE THE FOLLOWING SYMPTOMS OR CONDITIONS **(Don't know is No)**

Any 1 or more (Check all that apply)

- □ Snore loudly (enough to hear through closed doors)?
- □ Often feel tired, fatigued, or sleepy during daytime?
- □ Has anyone observed you stop breathing during sleep?
- □ Do you Choke or Gasp at night?
- □ Is your BMI 35 or more?
- □ Epworth Score of 10 or more? (see below)

Any 3 or more (Check all that apply)

- □ Have or are treated for high blood pressure?
- □ Are you over 50 yrs. old?
- □ Is your BMI 30 – 34?
- □ Are you a Male?
- □ Neck circumference more than 17 inches (M)?
- □ Neck circumference more than 16 inches (F)?
- □ Impaired Cognition/Memory?
- □ Mood disorder/Irritability?
- □ Insomnia?
- □ Coronary Heart Disease?
- □ Morning Headache?
- □ History of TIA or Stroke?
- □ Indigestion/ Heartburn/Reflux?
- □ Have or are being treated for Atrial Fibrillation?
- □ Type 2 Diabetes?
- □ Close relative with sleep apnea?
- □ Erectile Dysfunction (ED)?
- □ Restless Legs or Leg Jerks?
- □ Teeth Grinding (Bruxism)?
- □ Urinate at night or bed wetting?
- □ Are you on Dialysis?
- □ Drowsy Driving or Recent Traffic Accident?

EPWORTH SLEEPINESS SCALE

CIRCLE how likely are you to doze off or fall asleep (not just tired) in the following situations? (usual way of life in recent times)

0 = No chance of dozing **1 = Slight chance of dozing** **2 = Moderate chance of dozing** **3 = High chance of dozing**

Situation				
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g. at a theater or at a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3

EPWORTH SLEEPINESS SCALE .... **TOTAL SCORE ____**

PHYSICAL EXAMINATION

Height ___ ft ____ in **Weight** _____ lb **BMI** _____
Neck Circumference ____ in
Sex □ M □ F **HR** ____ bpm **BP** _____ / ____
Chest □ Clear □ Rales □ Ronchi □ Wheezes □ _____________
Heart □ Regular □ Irregular □ Murmur □ Gallop □ ___________

- □ Crowded Pharynx
- □ Large Tonsils
- □ Large Tongue
- □ Large Uvula
- □ Abnormal Jaw
- □ Retrognathia
- □ Micrognathia
- □ Over/Under bite

PHYSICIAN ORDER: Home Sleep Test, Level III (CPT-4 G0399 or 95806) □ Initial □ Follow up

DIAGNOSIS: □ Obstructive Sleep Apnea (ICD-9/327.23) □ Sleep Apnea Unspecified (ICD-9/780.57)

I certify that I have completed a clinical evaluation documenting medical necessity prior to ordering this home sleep test for the above patient and that this order is not for screening of an asymptomatic patient.

SIGNATURE ___________________________ **DATE:** ____________

FAX To: Medical Diagnostic Solutions
877-611-6844

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