Advanced Diagnostic Solutions, Inc.
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# Unattended Home Sleep Test Rx

P: (727) 841-9219 Option #2
F: (727) 264-2117
www.advdiagnsotic.com/HST

## 1 Patient Information

Patient Name: _____ ○ Male ○ Female DOB: _____

Address: _____ City/State/Zip: _____

Phone: _____ Alt Phone: _____

Primary Ins: ○ Medicare ○ Commercial Plan: _____ ID #: _____

***Nationally Accepted Insurances: Humana, Medicare, Tricare, BCBS, Aetna, Coventry, Cigna & Medicare Advantage Plans***

Secondary Ins: _____ ID #: _____

Weight: _____lbs Height: _____FT _____IN Neck Circumference: _____IN BMI: _____

Ordering Physician: _____ NPI: _____

Phone: _____ Fax: _____ Email: _____

Local DME Supplier: _____

Phone: _____ Fax: _____ ***(Send a copy of the Final Results to this DME/HME Supplier)***

## 2 Face-to-Face Clinical Exam: Required to be documented in patient's medical record.

Sleep History & Symptoms: ***(Check ALL that are applicable)***

○ Snoring ○ Daytime Sleepiness ○ Observed Apneas ○ Choking or Gasping during Sleep ○ Morning Headaches
○ Tired/Fatigued ○ Other *(Describe Nature)*:

Focused CardioPulmonary & Upper Airway Evaluation: ***(Check ALL that are applicable)***

○ Large Tongue ○ Enlarged Tonsils ○ Large Uvula ○ Overbite ○ Under bite ○ Crowded Oropharynx
○ Worn Teeth ○ Nasal Obstruction ○ Hypertension ○ Obesity ○ Other *(Describe Nature)*:

Epworth Sleepiness Scale: ***How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?***

0 – ***NO*** chance of dozing 1 – ***SLIGHT*** chance of dozing 2 – ***MODERATE*** chance of dozing 3 – ***HIGH*** chance of dozing

____ Sitting & Reading ____ In car stopped in traffic for few mins. ____ Sitting inactive in public ____ Lying down to rest in afternoon
____ Watching TV ____ Passenger in Car for hour w/o break ____ Sitting quietly after lunch w/o alcohol ____ Sitting & Talking

Epworth Score: _____ ***(Normal Epworth Score is considered below 8)***

## 3 Prescription for Diagnostic Procedure

Diagnosis: ***(*Please check one diagnosis. If left blank, the physician/practitioner chooses to use G47.33)***

○ G47.30 – Unspecified Sleep Apnea ○ G47.33 – Obstructive Sleep Apnea (Use this for suspected or to confirm OSA)
○ G47.10 – Hypersomnia, unspecified ○ R09.02 – Hypoxemia

**If the diagnosis is left blank, the physician or practitioner agrees to use G47.30 or G47.33 based on insurance guidelines.*

Unattended Home Sleep Test up to Two Nights |Test Condition: ○ Room Air ○ PAP Titration ○ w/ Oral Appliance *[Room Air if Blank]*

**Physician/Practitioner Certification** I, the undersigned, certify that I have completed the requirements according to CMS guidelines prior to ordering this Unattended Home Sleep Test for this patient. I further agree that this order is not for screening purposes of an asymptomatic patient & understand that CMS coverage guidelines require a **face – to – face evaluation,** relating to section two above, must be documented in the patient's medical chart prior to a HST is ordered. ***By signing below, I find that it is medically necessary to have this Unattended Home Sleep Test completed.***

**Signature:** _____ **Date:** _____ / _____ / _____

## 4 FAX THIS FORM WITH RECENT CLINICALS TO ADSI AT (727) 264-2117