BLACKSTONE MEDICAL SERVICES

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PHYSICIANS ORDER FOR HOME SLEEP TEST

Patient Name:_____ SSN:_____

DOB:_____ Best / Daytime Phone #:_____ Alternate Phone #:_____

Street Address:_____ Email address:_____

City:_____ State:_____ Zip: _____ ☐ Male ☐ Female

Primary Insurance:_____ ID No: _____

Secondary Insurance:_____ ID No: _____

Height: _____ **Weight:** _____ **BMI:** _____ **Neck Circumference:** _____

Patient on Supplemental Oxygen: Yes___ No___ **Patient Currently on PAP therapy: Yes___ No___**

STUDY REQUESTED (CPT-4)

☐ 95806 / G0399 Home Sleep Test

CHIEF COMPLAINT:

☐ Snoring ☐ Observed Apnea
☐ Choking or Gasping during sleep ☐ Fatigue
☐ Excessive Daytime Sleepiness ☐ Hypertension
☐ Other_____

DIAGNOSIS CODE (ICD-10)

☐ G47.33 Obstructive Sleep Apnea
☐ G47.30 Sleep Apnea, Unspecified
☐ G47.39 Other Sleep Apnea

EPWORTH SLEEPINESS SCALE: *(**For Insurance Purposes:** assessment below must be completed prior to ordering a HST)*
0 - NO Chance of Dozing **1 - SLIGHT** Chance of Dozing **2 - MODERATE** Chance of Dozing **3 - HIGH** Chance of Dozing

	0	1	2	3		0	1	2	3
Sitting and Reading	☐	☐	☐	☐	Lying down to rest in the afternoon	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	Sitting & Talking w/ someone	☐	☐	☐	☐
Sitting inactive in a public place	☐	☐	☐	☐	Sitting quietly after lunch w/o alcohol	☐	☐	☐	☐
Passenger in car under an hour	☐	☐	☐	☐	In a car stopped in traffic	☐	☐	☐	☐

Physician Name:_____ Phone:_____

Address:_____

Physician Signature:_____ Date:_____

Physician NPI #:_____ Office Contact / Title:_____

Fax Results:_____

Preferred DME Company

Company Name: _____

Fax Number: _____