



To fill out/sign electronically
please download the form first and
open in documents.

Phone: (208) 914-5977
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Email: Support@valleysleepid.com

Patient Name:		DOB:	Preferred Phone:	
Address:		City:	State:	Zip:
Height:	Weight:	Neck Size:	Gender:	
MEDICAL ORDER (Along with medical order please send over recent chart notes discussing need for sleep study)				
Provider Name:		Address:		
Name of Practice:		City:		
Phone:		State:	Zip:	
Fax [to send patient test results]:		E-mail:		
<p>By signing below, I attest that based on my examination of the patient and his/her medical history, there is a high probability of Obstructive Sleep Apnea. An unattended, type IV Home Sleep Test is medically necessary. No co-morbid conditions including, but not limited to, moderate to severe COPD, CHF, OHS, neurodegenerative disorder or cognitive impairment are present that prevent the patient from home sleep testing:-</p> <p>Test ordered: Type IV unattended home sleep test ICD-10 code: Default to G47.30 or Other code: _____ CPT code: G0400, 95800 and 98960 Additional Comments: _____</p> <p>Provider Signature: _____ Date of Order: _____</p>				
Patient Clinical Indication and Medical History Details (check all that apply for the patient)				
<input type="checkbox"/> Witnessed apnea events during sleep greater than 10 seconds in duration	<input type="checkbox"/> Excessive Daytime Sleepiness		<input type="checkbox"/> Snoring	<input type="checkbox"/> Non-restorative, disturbed or restless sleep
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Hypertension/High Blood Pressure		<input type="checkbox"/> Gasping/Choking	<input type="checkbox"/> Daytime Fatigue
Complete this section ONLY if re-testing the patient Prior DX of Apnea? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, Test Date: _____)				
A new sleep test is indicated due to (check all that apply):				
<input type="checkbox"/> Weight gain or loss (>10% or BMI >5)	<input type="checkbox"/> Evaluate therapy effectiveness	<input type="checkbox"/> Evaluate need to continue therapy		
Is the test: <input type="checkbox"/> Pre <input type="checkbox"/> Post treatment? Indicate type of treatment: <input type="checkbox"/> Surgery <input type="checkbox"/> Oral Appliance <input type="checkbox"/> PAP <input type="checkbox"/> Other				
Patient's Primary / Secondary Insurance		Name of Insured (if not patient):		
Primary Insurance Name:		Group #	ID #	
Secondary Insurance Name:		Group #	ID #	
Send Test Report to DME?	<input type="checkbox"/> Yes	DME Name:	Fax:	