Valley Sleep
DIAGNOSTICS

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Patient Name:	**DOB:**	**Preferred Phone:**	
Address:	City:	State:	Zip:
Height:	Weight:	Neck Size:	Gender:

MEDICAL ORDER (This section **BELOW** may be replaced by an *approved* Electronic Medical Order)

Provider Name:	Address:	
Name of Practice:	City:	
Phone:	State:	Zip:
Fax [to send patient test results]:	E-mail:	

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.

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:_____

Provider Signature: _____ **Date of Order: _____**

Patient Clinical Indication and Medical History Details (check all that apply for the patient)

- ☐ Witnessed apnea events during sleep greater than 10 seconds in duration
- ☐ Non-restorative, disturbed or restless sleep
- ☐ Excessive Daytime Sleepiness
- ☐ Snoring
- ☐ Gasping/Choking
- ☐ Insomnia
- ☐ Hypertension/High Blood Pressure
- ☐ Daytime Fatigue

Complete this section ONLY if re-testing the patient Prior DX of Apnea? ☐ No ☐ Yes (If yes, Test Date: _____)

A new sleep test is indicated due to (check all that apply):

☐ Weight gain or loss (>10% or BMI >5) ☐ Evaluate therapy effectiveness ☐ Evaluate need to continue therapy

Is the test: ☐ Pre or ☐ Post treatment? **Indicate type of treatment:** ☐ Surgery ☐ Oral Appliance ☐ PAP ☐ 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? ☐ Yes DME Name: Fax: