Sleep Study - Rx

Connect DME

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Patient Name: _____ DOB: _____

Phone: _____ Email: _____

Address:_____ City:_____ State/ZIP: _____

Procedure Requested: **Procedure Code**:

____ Home Sleep Test (unattended in-home test) (95806)

____ In Lab Sleep Test (95811)

Patient History: Patient Neck Size_____ Patient Height_____ Patient Weight_____

Indications:

___Excessive Daytime Sleepiness	___Witnessed Apnea	___Insomnia
___ Snoring	___Bruxism (Teeth Grinding)	___Morning Headaches
___ Hypertension	___Depression	___Seizures
___Muscle/Joint Aches	___Congestive Heart Failure	___Restless Legs

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale to choose the most appropriate number for each situation:
It is important that you answer each question as best you can. Situation Chance of Dozing (0-3)

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

	Circle
Sitting and reading	0 1 2 3
Sitting, inactive in a public place (e.g. a theatre or a meeting)	0 1 2 3
Watching TV	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 a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in the traffic	0 1 2 3

I certify that I am the physician identified in this form. I have reviewed the Detailed Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in is true, accurate and complete to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed or will be trained on the proper use of products prescribed on this Written Order. The products lists and physician notes and other supporting documentation will be provided to DME and/or an authorized distributor upon request. I acknowledging that the patient is aware that DME and/or an authorized distributor may contact them for any additional information to process this order. A copy of this order will be retained as part of the patient's medical record.

X_____ X_____/_____

Physician Signature Date Printed Name