



Sleepwatchers, LLC

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## HOME SLEEP APNEA TESTING ORDER

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Mobile #: \_\_\_\_\_

1.	SERVICES	SYMPTOMS / DIAGNOSIS	OPTIONS
<input type="checkbox"/>	Sleep Evaluation – 9920x	<input type="checkbox"/> EDS Hypersomnia – G47.10	<input type="checkbox"/> Face to Face <input type="checkbox"/> Virtual
<input type="checkbox"/>	At-Home Sleep Apnea Test - 95800 / 95806	<input type="checkbox"/> Snoring – R06.83	<input type="checkbox"/> No Preference <input type="checkbox"/> WatchPAT One (Disposable) <input type="checkbox"/> VirtuOx Dream (Reusable, 7 channels) <input type="checkbox"/> NightOwl (Reusable up to 10 nights) <input type="checkbox"/> SleepImage Ring (Reusable up to 3 nights)
<input type="checkbox"/>	with Oral Appliance	<input type="checkbox"/> Morning Headaches	
<input type="checkbox"/>	Pre-Op	<input type="checkbox"/> Gasping, choking or pauses in breathing sleep	
<input type="checkbox"/>	S/P Surgery	<input type="checkbox"/> Frequent Nighttime Urination	
		<input type="checkbox"/> Other:	

### 2. AASM CRITERIA FOR HSAT

	MUST BE YES TO ALL	MUST BE NO TO ALL
<b>HOME SLEEP TESTING IS NOT RECOMMENDED IF CRITERIA IS NOT MET</b>  <b>HOWEVER, PLEASE USE GOOD JUDGEMENT TO MAKE EXCEPTIONS AS NECESSARY TO ENSURE ACCURATE, CONVENIENT &amp; APPROPRIATE SERVICES FOR YOUR PATIENT</b>	<input type="checkbox"/> High Probability of Obstructive Sleep Apnea	<input type="checkbox"/> No Insomnia or Circadian Rhythm Disorders
	<input type="checkbox"/> BMI < 35 (unless asymptomatic & normal blood pressure)	<input type="checkbox"/> No Central Apnea, Cheyne-Stokes, Hypoventilation, or Sleep-related Hypoxemia
	<input type="checkbox"/> Age > 17 (or > 12 with NO health concerns)	<input type="checkbox"/> No Stroke in last 18 months
	<input type="checkbox"/> Patient reports excessive daytime sleepiness	<input type="checkbox"/> No history of Myocardial Infarction
	<input type="checkbox"/> Other witnessed Snoring or Apneas in Sleep	<input type="checkbox"/> No Heart Failure
	<input type="checkbox"/> Normal Blood Pressure (or well-controlled)	<input type="checkbox"/> No Pulmonary Disease
	<input type="checkbox"/> FEV > 65%	<input type="checkbox"/> No Neuromuscular Disease
	<input type="checkbox"/> Cognitively Able to Complete Testing	<input type="checkbox"/> No long-term opiate use
<input type="checkbox"/> Physically Able to Complete Testing	<input type="checkbox"/> No substance use disorder	

### 3. CHECKLIST OF SUPPORTING EVIDENCE

<b>IF IT IS REQUESTED TO AVOID THE SLEEP EVALUATION, THE CLINICAL EVIDENCE MUST SUPPORT MEDICAL NECESSITY FOR HSAT</b>	<input type="checkbox"/> Meets Medical Criteria for Home Sleep Testing	Although criteria is not met for HST, I prefer for my patient to complete a Home Sleep Test due to: <input type="checkbox"/> Medically Urgent <input type="checkbox"/> Previous PSG Completed <input type="checkbox"/> Repeat Testing Requested <input type="checkbox"/> Insurance Requirements
	<input type="checkbox"/> Provider Clinicals Attached as Evidence of MN	
	<input type="checkbox"/> The patient has not reported symptoms of other sleep disorders including RLS, PLMD, Narcolepsy, Parasomnias, Nightmares, Night Terrors, etc.	

### 4. ORDERING PROVIDER

NAME:	PHONE #:
NPI #:	FAX #:

PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PLEASE ATTACH ANY MEDICAL RECORDS THAT SUPPORT MEDICAL NECESSITY

**FAX TO: (888) 608-0343**