Local Home Health Provider

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Phone: _____

Fax: _____

EzSlēp
HSAT Your Way

Prescription and Clinical Evaluation

Customer Support: (877) 337-7111
Web: www.virtuox.net

1 Patient Information:

NAME		GENDER	DOB (mm/dd/yyyy)
ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL
PREFERRED WRITTEN LANGUAGE		PREFERRED SPOKEN LANGUAGE	
EMERGENCY CONTACT		EMERGENCY PHONE	

2 Insurance: ☐ Check here if self-pay

PRIMARY PAYER	ID #	GROUP #	PHONE
SECONDARY PAYER	ID #	GROUP #	PHONE

3 Prescriber Information:

NAME	ADDRESS	CITY / STATE / ZIP
PHONE	FAX	NPI
REFERRAL COORDINATOR	PHONE	EMAIL

4 Sleep History & Physical Exam: (Fill in the blanks and check all symptoms that apply)

Height: _____ **inches** **Weight:** _____ **lbs** **BMI:** _____ **Neck Size:** _____ **inches** **Sleep Epworth Score:** _____ **(0-24)**

☐ Sleep Disordered Breathing	☐ Loud Snoring	☐ Depression	☐ Insomnia
☐ Oral Appliance Assessment	☐ Non-Restorative Sleep	☐ Gasping / Choking	☐ Observed Apneas
☐ Excessive Daytime Sleepiness	☐ Morning Headaches	☐ Dry Mouth in A.M.	

5 Cardiopulmonary / Upper Airway Exam: (Check all that apply)

☐ Nasal Obstruction	☐ Over / Under Bite	☐ Crowded Oropharynx	☐ Hypertension
☐ Teeth Worn	☐ Enlarged Tongue	☐ Enlarged Tonsils	☐ Retrognathia / Micrognathia
☐ Maxillomandibular Abnormalities	☐ Crowded Hypopharynx	☐ Obesity	

6 Diagnostic Codes: (Check all ICD-10 codes that apply)

☐ G47.10 Hypersomnia, Unspecified ☐ G47.30 Sleep apnea, Unspecified ☐ G47.33 Obstructive sleep apnea (adult) (pediatric)

7 Home Sleep Test Procedure:

2-nights unattended, Portable Recorder with minimum four (4) channels, for example: Records airflow, respiratory effort, O_2 saturation and heart rate. Performed on room air unless specified below.

☐ **Home Sleep Test with Room Air**

☐ **Home Sleep Test with Oxygen**
LPM: _____

☐ **Home Sleep Test with PAP**
PAP Pressure: _____
Fixed / Auto pressure

☐ **Home Sleep Test with Oral Appliance**

☐ **Home Sleep Test with DOT certification**

8 Prescriber Signature & Certification: (Stamped dates / signatures not valid. Must be signed by Prescriber / PA / NP)

I, the undersigned, certify that I am the patient's treating prescriber and that the information contained on this form is based on a face-to-face office visit. I am prescribing a two-night serial HST as medically necessary to validate results because of night to night variability.

Sign Here: _____ **Date:** _____

Please fax completed order form & insurance card back to (800) 209-9193