Local Home Health Provider

_____

_____

_____

Phone: _____

Fax: _____

VirtuSOM Program Overnight EEG Order Form

Prescription and Clinical Evaluation

VIRTUOX

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

1 Patient Information:

NAME	GENDER	DOB (mm/dd/yyyy)	SS#
ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL

PREFERRED WRITTEN LANGUAGE	PREFERRED SPOKEN LANGUAGE
EMERGENCY CONTACT	EMERGENCY PHONE

2 Prescriber Information:

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

3 Insurance: ☐ Check here if self-pay

PAYOR NAME 1	ID#	GROUP#	PHONE
PAYOR NAME 2	ID#	GROUP#	PHONE

4 Sleep History: (Check all conditions that could be impacting sleep quality)

Comorbidities:	☐ Insomnia	☐ Diabetes	☐ Depression	☐ TBI
	☐ Hypertension	☐ Morbidly obese	☐ Anxiety	☐ PTSD
Currently prescribed:	☐ Benzodiazepine	☐ Other sleeping aid	☐ Antidepressant	☐ Antianxiety
	☐ Anticonvulsant	☐ Opioid	☐ Nerve pain	☐ CNS stimulant

5 Diagnostic Codes: (Check all Diagnosis codes that apply)

Hyposomnia / Insomnia

- ☐ F51.03 Paradoxical insomnia
- ☐ F51.09 Other insomnia not due to a substance or known physiological condition
- ☐ G47.00 Insomnia, unspecified

Hypersomnia

- ☐ G47.11 Idiopathic hypersomnia with long sleep time
- ☐ R53.83 Other Fatigue
- ☐ G47.8 Other Sleep Disorders

Hypersomnia with comorbid depression

- ☐ F51.12 Insufficient Sleep Syndrome
- ☐ F51.19 Hypersomnia

Sleep quality potentially impacted by mental state

- ☐ F41.9 Anxiety disorder, unspecified

Memory potentially impacted by sleep quality

- ☐ G31.84 Mild cognitive impairment

6 VirtuSOM Overnight EEG Test Procedure:

☐ **Medication Validation Program**

Used to verify patients need for sleep medications prior to prescribing

Night 1 EEG

Auto Enroll in CBT-I if recommended

Auto Repeat EEG for 1 night after CBT-I

☐ **Medication Titration Program**

Used to verify the lowest dosage required to obtain optimum sleep

Medication: _____

Night 1 EEG & dosage: _____

Night 2 EEG & dosage: _____

Night 3 EEG & dosage: _____

☐ **Medication Elimination Program**

Used to eliminate sleep medications and replace with CBT-I the gold standard for Insomnia

Medication: _____

Night 1 EEG & dosage: _____

Night 2 EEG & dosage: _____

Night 3 EEG & dosage: _____

Auto Enroll in CBT-I if recommended

Auto Repeat EEG for 1 night after CBT-I

7 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 up to a three-night overnight EEG to assess sleep quality, conduct sleep medication titration or assess the need for sleep medications.

Sign Here: X _____ **Date:** _____

Please fax completed order form & insurance card back to (866) 912-2631

v 11.16.2018