iSleep is powered by IXE Healthcare Group.

HOME SLEEP TEST ORDER FORM

SUBMIT VIA:
FAX: 1-855-380-3593
SECURE EMAIL: INFO@ISLEEPHST.COM
FOR ASSISTANCE, PLEASE CALL: 1-833-475-3372

PRESCRIBER INFORMATION

Ordering Provider Name ______________________ **NPI** ______________________

Phone ______________________ **Fax** ______________________

Office Contact Name ______________________ **Phone (With extension if applicable)** ______________________

PATIENT INFORMATION

Last Name ______________________ **First Name** ______________________

Language ______________________ **Date of Birth (mm/dd/yyyy)** ______________________

Gender ☐ Male ☐ Female **Height** ______________________ **Weight** ______________________

Address **(please include apt #, unable to ship to post boxes)** ______________________

City ______________________ **State** ______________________ **Zip** ______________________

Cell Phone (with area code) ______________________ **Home Phone** ______________________ **Email** ______________________

Insurance Company and ID ______________________

DIAGNOSIS / MEDICAL HISTORY / SYMPTOMS

ICD-10 Code G47.33 will be used for this Obstructive Sleep Apnea (OSA) test unless specified otherwise. (If other, specify:)
Medical Necessity of Home Sleep Testing: **1) Please check ALL symptoms that apply. 2) Please attach any medical documentation / progress notes regarding testing for Sleep Apnea.**

☐ Witnessed Apneic Events
☐ Habitual Snoring (R06.83)
☐ Excessive Daytime Sleepiness
☐ Hypertension
☐ Previous Diagnosis of OSA
☐ Gasping / Choking
☐ Non-Restorative Sleep
☐ Drowsy Driving
☐ Morning Headaches
☐ Test with Oral Appliance
☐ Other (specify): ______________________

Does patient have CHF? ☐ Yes **Does patient have COPD?** ☐ Yes If **Yes**, what is the severity? ☐ Mild ☐ Moderate ☐ Severe

Enter Epworth Sleepiness Scale Score (Range 0 – 4; > 10 = High Risk):

DESIGNATED THERAPY/DURABLE MEDICAL EQUIPMENT (DME) PROVIDER AND RELEASE OF TEST RESULTS
By entering contact information below, provider directs that any test results (whether positive or negative) additionally be sent to the therapy/DME provider for purposes of treatment of the patient.

Therapy / DME Provider ______________________ **Phone** ______________________ **Fax** ______________________

By signing below, I attest that: upon my examination of the patient, which included HEENT, Cardiovascular, Chest/Lung, Neurological and Vital Signs, there is a high probability of OSA. A Home Sleep Test is medically necessary and no co-morbid conditions are present that prevent the patient from home testing.

Provider's Original Signature ______________________ **Date** ______________________

For internal use. Account Manager *William McLaughlin*