

*Pulmonary and Sleep
Associates of Marin*



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MarinPulmonarySleep.com

DIRECT HOME SLEEP APNEA TESTING ORDER FORM

Patient's Name: _____ DOB: _____

Phone: _____

Insurance Name: _____

Referring Physician's name: _____ Phone: _____

Check all boxes that apply. The patient has (*Required for order):

- Loud snoring (R06.83)
- Witnessed apnea (R06.81)
- Excessive daytime sleepiness (Epworth score >10) (R40.0)
- Nocturia (R35.1)
- Bruxism (G47.63)
- Fragmented sleep with secondary insomnia (F51.01)
- Morbid Obesity, BMI ≥ 40 (E66.9)

As per accompanying instructions, the patient should be > 18 years of age and **NOT** have:

- Cognitive or language barriers that interfere with test administration
- Moderate to severe chronic obstructive pulmonary disease (COPD)
- Neuromuscular disease
- Congestive heart failure
- Suspected central sleep apnea
- Suspected periodic limb movement disorder (PLMD)
- Primary insomnia
- Circadian rhythm disorders
- Suspected Parasomnias
- Suspected Narcolepsy

Please provide the patient's **Demographics and Insurance** information along with this order. In cases where a prior authorization is required, we will request that on the patient's behalf.

I would like to proceed with home sleep apnea testing at Pulmonary and Sleep Associates of Marin.

Referring Physician's Signature

Date