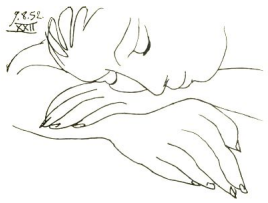
Pulmonary and Sleep Associates of Marin



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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, G47.14)
- ☐ 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 (chronic opiate use or stroke)
- Suspected periodic limb movement disorder (PLMD)
- Chronic 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