APRIA®

Home Sleep Test Order Form

Fax: _____

Home Sleep Test Provider Name _____

Apria Representative _____ **Branch Location** _____ **Phone** _____

REFERRAL SOURCE

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

PATIENT INFORMATION

Patient name _____ DOB _____
LAST FIRST

Address _____ MBI/INS ID # _____

Home phone _____ Mobile phone _____ Email _____

Diagnosis ICD-10: A specific ICD-10 code must be provided either on the line below or in the patient's chart notes. Please check the appropriate diagnosis or write in the code and description. Ranges will not be accepted.

☐ G47.33 Obstructive Sleep Apnea (OSA) ☐ Other _____

PLEASE INCLUDE ALL OF THE FOLLOWING REQUIRED DOCUMENTATION:

- Copy of patient demographics and insurance information. Height: _____ inches, Weight: _____ lbs, BMI: _____, Neck circumference _____
- Face-to-face evaluation/patient chart notes documenting signs and symptoms of OSA, signed and dated prior to sleep study

SLEEP HISTORY AND PHYSICAL

Check all that apply.

☐ Sleep disordered breathing
☐ Observed apnea
☐ Non-restorative sleep
☐ Loud snoring
☐ Morning headaches
☐ Morning dry mouth
☐ Excessive daytime somnolence
☐ Awakening gasping for breath
☐ Depression

FOCUSED CARDIOPULMONARY / UPPER AIRWAY EXAM

Check all that apply.

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

SLEEP EPWORTH EXAM

Please rate the patient's rate of dozing.

0 = No chance of dozing 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

___ Sitting and reading
___ Sitting quietly after lunch without alcohol
___ Lying down to rest in afternoon
___ Sitting and talking with someone
___ In car stopped in traffic
___ Sitting inactive in public place
___ As a passenger in car < 1 hr
___ Watching TV

DIAGNOSTIC ORDERS

☐ Perform home sleep test with four or more channels on patient's current oxygen prescription of _____ LPM or on room air.

Apria cannot coordinate home sleep testing for patients insured by Medicare, or payors who follow Medicare guidelines. For these patients, please send the home sleep testing order directly to the Independent Diagnostic Testing Facility.

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

Print prescriber's name _____ **Prescriber email** _____ **NPI #** _____

Prescriber's address _____

Prescriber's signature _____ **Date** _____

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