BLACKSTONE MEDICAL SERVICES

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PHYSICIANS ORDER FOR HOME SLEEP TEST

Patient Name:_____ SSN:_____

DOB:_____ Best / Daytime Phone #:_____ Alternate Phone #:_____

Street Address:_____ Email address:_____

City:_____ State:_____ Zip: _____ ☐ Male ☐ Female

Primary Insurance:_____ ID No: _____

Secondary Insurance:_____ ID No: _____

Height: _____ **Weight:** _____ **BMI:** _____ **Neck Circumference:** _____

Patient on Supplemental Oxygen: Yes___ No___ **Patient Currently on PAP therapy: Yes___ No___**

STUDY REQUESTED (CPT-4)

☐ 95806 Home Sleep Test (Non-Medicare)
☐ G0399 Home Sleep Test (Medicare patients)

CHIEF COMPLAINT:

☐ Snoring ☐ Observed Apnea
☐ Choking or Gasping during sleep ☐ Fatigue
☐ Excessive Daytime Sleepiness ☐ Hypertension
☐ Other_____

DIAGNOSIS CODE (ICD-10)

☐ G47.33 Obstructive Sleep Apnea
☐ G47.30 Sleep Apnea, Unspecified
☐ G47.39 Other Sleep Apnea

EPWORTH SLEEPINESS SCALE: (***For Insurance Purposes:*** *assessment below must be completed prior to ordering a HST)*
0 - NO Chance of Dozing **1 - SLIGHT** Chance of Dozing **2 - MODERATE** Chance of Dozing **3 - HIGH** Chance of Dozing

	0	1	2	3		0	1	2	3
Sitting and Reading	☐	☐	☐	☐	In a car stopped in traffic	☐	☐	☐	☐
Passenger in car under an hour	☐	☐	☐	☐	Sitting quietly after lunch w/o alcohol	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐	Sitting inactive in a public place	☐	☐	☐	☐
Sitting & Talking w/ someone	☐	☐	☐	☐	Watching TV	☐	☐	☐	☐

Physician/Practitioner Signature:_____ Date:_____

Name (Printed):_____

NPI #_____ Office Contact Person_____ Phone #_____

Address:_____
(Street) (City) (State) (Zip)

Fax Results to fax number:_____

DME/Rep: Tanglewood Medical Supplies, Inc
P: 254-968-6999 Fax: 254-968-6167