HME HOME MEDICAL EQUIPMENT LOCATIONS

Sleep Study Order For www.HMELocations.com

Patient Information

Name _____ Gender ( ) M ( ) F Date of Birth _____
Address _____ City _____ State _____ Zip _____
Home Ph: _____ Cell Ph: _____ Work Ph: _____
Primary Insurance: _____ Policy # _____
Secondary Insurance:_____ Policy # _____

Prescription - Certificate of Medical Necessity

All necessary supplies are sold to the patient under this prescription

Sleep Physician Consultation

- If the referring physician **does not have** the **necessary insurance documentation and clinical notes** for the Sleep Study, a consultation with a Board Certified Sleep Specialist **should be scheduled in order to evaluate the patient.**

Check here for consultation with Sleep Specialist for ***all other sleep disorders***.

Sleep Study

( ) PSG, ( ) CPAP/BiPAP, ( ) MSLT, ( ) MWT, ( ) Other _____

Reason for Study (check all that apply)

( ) **Observed Apnea** ( ) **Suspected Central Sleep Apnea** ( ) **Suspected Parasomnia** ( ) **Suspected Periodic Leg Movement** ( ) **COPD moderate to severe** ( ) **Oxygen Dependent**	( ) Suspected Narcolepsy ( ) Treatment Resistant HTN ( ) CVA (within 30 days) ( ) Heart Disease, ( ) Advanced CHF ( ) BMI > 33 and HCO3– >28mmol/L ( ) Current use of opiates or narcotics ( ) Documented Obesity Hypoventilation	( ) Epworth Sleep Scale > 10 ( ) Excessive Daytime Sleepiness ( ) Suspected Idiopathic Hypersomnia ( ) OSA - with continuing symptoms ( ) Habitual snoring, gasping, choking that awakens patient (R/O OSA)

Is patient able to follow directions Y ___ N___ Does patient have a physical impairment Y ___ N___

Please fax medical notes and medication list to doctor's office.
Physician's face-to-face notes should provide the correct diagnoses necessary for the Sleep Study.
If patient had a previous sleep study at another facility, please fax results.

Height _____ Weight _____ BMI _____ Neck circumference >17" males, > 16" females _____

Prescriptions for sleep studies include Durable Medical Equipment (Sleep System) and all of the related medical supplies. These supplies include, and are not limited to: gloves, medical tape, lemon prep, oximetry supplies, nasal cannulas, EKG, EEG & all other medical supplies **which are sold to the patient & used by the patient/consumer as supplied** under this prescription under the billable codes: PSG 95810, CPAP titration 95811, MSLT 95805, HST 95806

Print MD Name _____ Group Name _____
Address _____
Phone # _____ Fax # _____

I certify that I am the treating physician and I have had a face-to-face evaluation with this patient prior to ordering these services. I have completed this Certificate of Medical Necessity form and any statements here have been reviewed and signed by me. I certify that the medical information is true, accurate, and complete to the best of my knowledge. I certify that the above test / equipment ordered are medically necessary in the treatment of this patient.

Physician Signature _____ NPI # _____ Date _____