

Home Sleep Test and CPAP Auto Titration Order Form

Home Sleep PAP Provider APRIA HEALTHCARE

Requested Sleep PAP Provider _____

FAX to _____ at _____

For more information about Home Sleep Testing call _____ at _____

REFERRAL SOURCE

Date _____ Region _____

Office name _____

Office contact name _____

Phone _____ Fax _____

PATIENT INFORMATION

Patient name _____
Last First

DOB _____ Home phone _____

Mobile phone _____

PLEASE SEND PATIENT DEMOGRAPHICS, INSURANCE INFORMATION AND FACE-TO-FACE DOCUMENTATION

Face-to-face documentation is a REQUIREMENT for many PAP setups. Please document all aspects of this form into your normal charting format.

SLEEP HISTORY AND PHYSICAL

(Must have at least one checked off. Insurance requirement.)

- | | |
|---|---|
| <input type="checkbox"/> Sleep disordered breathing | <input type="checkbox"/> Morning dry mouth |
| <input type="checkbox"/> Observed apnea | <input type="checkbox"/> Excessive daytime somnolence |
| <input type="checkbox"/> Non-restorative sleep | <input type="checkbox"/> Awakening gasping for breath |
| <input type="checkbox"/> Loud snoring | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Morning headaches | |

FOCUSED CARDIOPULMONARY / UPPER AIRWAY EXAM

(Must have at least one checked off. Insurance requirement.)

- | | |
|--|--|
| <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Teeth Worn | <input type="checkbox"/> Enlarged Tonsils |
| <input type="checkbox"/> Maxillomandibular Abnormalities | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Over/Under Bite | <input type="checkbox"/> Crowded Oropharynx |
| <input type="checkbox"/> Enlarged Tongue | <input type="checkbox"/> Retrognathia/Micrognathia |
| <input type="checkbox"/> Crowded Hypopharynx | <input type="checkbox"/> Performed but N/A |

SLEEP EPWORTH EXAM

(Please rate patient's rate of dozing. Insurance requirement.)

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

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

PHYSICAL EXAM

(BMI and neck circumference are required.)

Height: _____ inches Weight: _____ lbs.

BMI: _____ Neck circumference: _____

DIAGNOSTIC ORDERS

- For Oxygen Patients.** Perform HST with four or more channels on current oxygen prescription.
- For Non-Oxygen Patients on Room Air.** Perform HST with four or more channels on room air.

DIAGNOSIS — ICD-10

- G47.33 Obstructive Sleep Apnea
- Other _____

SLEEP THERAPY

Face-to-Face Evaluation date _____

If AHI is > 5 based on the ordered home sleep test, please set my patient up on the following PAP equipment:

- Standard Auto CPAP with setting of 4 cm H₂O to 20 cm H₂O with comfort settings
- Heated Humidifier
- PAP mask — Patient to choose mask to comfort

Estimated length of need: _____ months

- Opt-Out for PAP order:** Contact me for PAP order after sleep study results are available.

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 a medication 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.

Practitioner name (print) _____ NPI # _____

Practitioner signature _____ Date _____