Home Sleep Test and CPAP Auto Titration Order Form

Home Sleep PAP Provider APRIA HEALTHCARE

Requested Sleep PAP Provider _____

FAX to Apria Healthcare **at** 608-222-2768

For more information about Home Sleep Testing call Apria Healthcare **at** 608-423-5190

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.)

- ☐ 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

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

- ☐ 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 patient's rate of dozing. Insurance requirement.)

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

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 H_2O to 20 cm H_2O 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** _____