Apnea Simplified
www.apneasimplified.com
1-800-419-0210
FAX ORDER TO
1-888-251-1922

HOME SLEEP TEST REFERRAL FORM

Date: _____

Pateint Name: _____ DOB: _____

Phone (Home): _____ Phone (Cell): _____

Patient's Height: _____ Weight: _____ BMI (Body Mass Index): _____ Male: ___ Female: ___

Physician/NP: _____ NPI: _____

Physician Phone (Office): _____ (Fax): _____

Physician / NP Signature. : _____ ***(Signature required to perform services)***

SLEEP TESTING OPTIONS:

- ☐ Diagnostic Home Sleep Test (HST) CPT: 95800
- ☐ Efficacy HST with Oral Appliance CPT: 95800
- ☐ Efficacy HST with PAP Device CPT: 95800

DIAGNOSIS / HISTORY

- ☐ Obstructive Sleep Apnea (OSA) G47.33
- ☐ Central Sleep Apnea G47.31
- ☐ Primary Snoring R06.83
- ☐ Insomnia G47.00

INDICATION(S) FOR REFERRAL (check all that apply):

- ☐ Snoring
- ☐ Daytime Sleepiness
- ☐ Witnessed Apnea
- ☐ Obesity
- ☐ Hypertension
- ☐ Morning Headache
- ☐ Insomnia
- ☐ Impaired Cognition
- ☐ Depression
- ☐ Fatigue
- ☐ Asthma
- ☐ Bruxism
- ☐ Arrhythmia
- ☐ A-Fib
- ☐ CHF
- ☐ CAD
- ☐ Diabetes
- ☐ COPD

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