

Physician's Order Referral for Sleep Study

Patient Name _____, D.O.B. _____, ___M ___F

Located at _____ City _____ State _____

has been evaluated for obstructive sleep apnea and/or similar related sleep disordered breathing. A further review for sleep apnea needs to be preformed and is medically necessary based upon the following clinical conditions.

Patient history reveals the following conditions:

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure/hypertension | <input type="checkbox"/> Swelling of the feet/pedal edema |
| <input type="checkbox"/> Depression/irritability | <input type="checkbox"/> Obesity #_____lbs overweight |
| <input type="checkbox"/> Impotency (ED) | <input type="checkbox"/> Heart disease/ family hereditary |
| <input type="checkbox"/> Large neck 17> male, 15 ½> Fem | <input type="checkbox"/> ___Y ___N |
| <input type="checkbox"/> Allergic rhinitis/deviated septum | <input type="checkbox"/> ft ___in Height |
| <input type="checkbox"/> Type II diabetes | <input type="checkbox"/> Type I diabetes |
| <input type="checkbox"/> Smoking #___pack/day | <input type="checkbox"/> #___(daily) #___(wkly) |

NOTES:

The patient's sleep observer witnessed the preceding sleep abnormalities:

- | | |
|--|--|
| <input type="checkbox"/> Cessation of breathing | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Arousals thru choking & gasping | <input type="checkbox"/> Snoring/gargling during sleep |
| <input type="checkbox"/> Awakens with sore throat | <input type="checkbox"/> Daytime sleepiness/fatigue |

The factors shown indicate the high probability of sleep apnea, hypoventilation, or upper airway resistance, which should be treated if diagnostically confirmed through a sleep study. If interpreting physician recommends CPAP/BiPAP therapy, then interpreting physician may order DME.

Physician Information

Ordering Physician

Physician Lic. #

NPI #

Physician office address

City

State

Office phone

Office fax