

1. PATIENT INFORMATION

Last Name	First Name	Date of Birth	Height (inches)
Phone	Email	Gender at Birth	Weight (lbs)
		☐ Male ☐ Female	
Street Address (No P.O. Box)	City	State	Zip Code

2. INSURANCE & PAYMENT

Insurance (include copy of insurance card in fax)	Member ID

☐ Check box for self-pay home sleep test option: \$225

ORDER REQUEST (Check all that apply)

☐ Home Sleep Test (HST) - 2 Night Test

☐ Sleep Physician Telehealth Consultation

☐ CPAP Therapy Management After Diagnosis

4. RESULTS & NEXT STEPS (Choose one)

☐ Send sleep report to referring provider only

☐ Send report to referring provider + preferred DME (provide the DME name and fax number below)

☐ Send report to provider + sleep specialist contacts patient to follow up

DME Name DME Fax #

5. CLINICAL SYMPTOMS / MEDICAL NECESSITY

☐ Snoring	☐ Witnessed Apneas	☐ Daytime Fatigue	☐ Excessive Daytime Sleepiness
☐ Hypertension	☐ Obesity	☐ Diabetes	☐ Gasping During Sleep
☐ GERD	☐ Nocturia	☐ Unrefreshing Sleep	☐ Morning Headaches
Other	Epworth Score		

6. REFERRING PROVIDER

Provider Name	NPI Number		
Office Phone	Office Fax	Coordinator Name	Coordinator Email
Provider Signature	Date		