sleep metrics

Sleep well. Be well.

HST PRESCRIPTION

COMPLETE AND FAX ORDER TO: 503-905-8562

Please Include:
- A front/back copy of patient's insurance
- Sleep questionnaire results if available
- Chart notes relating to OSA concerns

1. PATIENT INFORMATION

Name: _____ DOB: _____ Sex: M / F

Address: _____

City: _____ State: _____ Zip: _____

: _____ Alt. : _____

Is the patient:
Currently on CPAP? Y / N
Currently on Oxygen? Y / N

Has the patient:
Taken a sleep study before? Y / N

Height: _____

Weight: _____

Neck Circ: _____

****A COPY (FRONT AND BACK) OF INSURANCE CARD IS REQUIRED WITH THIS FORM****

2. PRESCRIPTION

(Check One): **Unless otherwise indicated, all tests will be conducted over 2 nights to validate results

- ☐ **Diagnostic Home Sleep Test**
- ☐ Home Sleep Test on PAP Therapy
- ☐ Home Sleep Test on Oral Appliance (to test efficacy of mandibular device)
- ☐ Home Sleep Test (other indications): _____

OSA ICD-10 CODES (Check all that apply):

- ☐ E66.01 Morbid Obesity
- ☐ G47.10 Hypersomnia, Unspecified
- ☐ G47.33 Obstructive Sleep Apnea
- ☐ G47.30 UNSPECIFIED SLEEP APNEA
- ☐ R09.02 Hypoxemia
- ☐ Other Code: _____
  Title: _____

Additional Instructions:

3. PROVIDER INFORMATION

Letter of Medical Necessity:
I, the undersigned certify that the above prescribed Home Sleep Test is medically necessary as part of my medical treatment for this patient. It is my opinion that the study ordered on this form is reasonable & necessary for accepted standards of medical practice and treatment of this patient's condition.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

NPI: _____

_____ _____
PROVIDER SIGNATURE **Date**

4. SEND WITH INSURANCE AND CHART NOTES TO 503-905-8562