



Toll-free: 877.837.5337 (SLEEP)
 Fax: 352.513.2549
 Address: 1980 N Prospect Ave, Lecanto, FL 34461
 Website: www.MHSleepTesting.com

MY HOME SLEEP TESTING | REFERRAL FORM

PATIENT NAME: _____ DOB: _____

PHONE: _____ CELL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

ALLERGIES: _____ HEIGHT/WEIGHT: _____ INSURANCE: _____

Please check one or both: **SLEEP CONSULT** **SLEEP STUDY**

SECTION A: REASON FOR STUDY

Please check all that apply below, including a **minimum of TWO** of the **bolded** symptoms.

- | | | |
|---|---|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> History of Stroke | <input type="checkbox"/> Impaired Cognition |
| <input type="checkbox"/> Ischemic Heart Disease | <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> Excessive Daytime Sleepiness |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Depression | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> COPD | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Morning Headache | |
| <input type="checkbox"/> Large Neck Size - 17" or greater for men / 16" or greater for women | <input type="checkbox"/> Nocturia | |

Is patient on oxygen? Yes No LPM _____

SECTION B: DIAGNOSTIC CODES

Please check at least ONE that applies.

- G47.33 Obstructive Sleep Apnea
- G47.10 Other Hypersomnia - Excessive Daytime
Somnolence

SECTION C: CPT HOME SLEEP TESTING

- Commercial 95800
- Medicare G0399
- Self-Pay \$169.00

STOP BANG QUESTIONNAIRE

- SNORING**- Do you snore loudly (louder than talking)? YES NO **BODY**- BMI more than 35kg? YES NO
- TIRED**- Do you often feel tired, fatigued or sleepy? YES NO **AGE**- Age over 50 years old? YES NO
- OBSERVED**- Has anyone observed you stop breathing? YES NO **NECK**- Neck circumference > 17 inches? YES NO
- PRESSURE**- Do you have/being treated for high BP? YES NO **GENDER**- gender male? YES NO

*SCORING CRITERIA: LOW RISK of OSA- YES 0-2 MODERATE RISK of OSA- YES 3-4 HIGH RISK of OSA- YES 5-8

Referring Physician Name (Printed)

Referring Physician Name (Signature)

Please fax this completed form to 352.513.2549. For faster service, please fax visit notes and a copy of the patient's insurance card (front and back). Thank you for your referral.