MHST™

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 <u>TWO</u>** of the **bolded** symptoms.

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

Is patient on oxygen? Yes No LPM ____

SECTION B: DIAGNOSTIC CODES

Please check at least <u>ONE</u> 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
- **TIRED**- Do you often feel tired, fatigued or sleepy? ☐ YES ☐ NO
- **OBSERVED**- Has anyone observed you stop breathing? ☐ YES ☐ NO
- **PRESSURE**- Do you have/being treated for high BP? ☐ YES ☐ NO
- **BODY**- BMI more than 35kg? ☐ YES ☐ NO
- **AGE**- Age over 50 years old? ☐ YES ☐ NO
- **NECK**- Neck circumference > 17 inches? ☐ 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.