Home Sleep Test and CPAP Auto Titration Order Form

APRIA HEALTHCARE®

Humana®

Home Sleep PAP Provider APRIA HEALTHCARE

Home Sleep Testing Provider VIRTUOX

FAX to Apria Home Sleep Central **at** 855-709-9967

For more information call Apria Home Sleep Central **at** 855-709-9966

REFERRAL SOURCE

Order Date _____

Referral name _____

Referral contact name _____

Phone _____ Fax _____

PATIENT INFORMATION

Patient name _____
Last First

DOB _____ Home phone _____

Mobile phone _____

Diagnosis ICD-10: A specific ICD-10 code must be provided either on the line below or in the patient's chart notes. Please check the appropriate diagnosis or write in the code and description. Ranges will not be accepted.

☐ G47.33 Obstructive Sleep Apnea (OSA) ☐ Other _____

PLEASE INCLUDE ALL OF THE FOLLOWING REQUIRED DOCUMENTATION:

- Copy of patient demographics and insurance information. Height: _____ inches, Weight: _____ lbs, BMI: _____, Neck circumference _____
- Face-to-face evaluation/patient chart notes documenting signs and symptoms of OSA, signed and dated prior to sleep study

SLEEP HISTORY AND PHYSICAL

(Must have at least one checked off. Insurance requirement.)

☐ Sleep disordered breathing
☐ Observed apnea
☐ Non-restorative sleep
☐ Loud snoring
☐ Morning headaches
☐ Morning dry mouth
☐ Excessive daytime somnolence
☐ Awakening gasping for breath
☐ Depression

FOCUSED CARDIOPULMONARY / UPPER AIRWAY EXAM

(Must have at least one checked off. Insurance requirement.)

☐ Nasal Obstruction
☐ Teeth Worn
☐ Maxillomandibular Abnormalities
☐ Over/Under Bite
☐ Enlarged Tongue
☐ Crowded Hypopharynx
☐ Hypertension
☐ Enlarged Tonsils
☐ Obesity
☐ Crowded Oropharynx
☐ Retrognathia/Micrognathia
☐ Performed but N/A

SLEEP EPWORTH EXAM

(Please rate patient's rate of dozing. Insurance requirement.)

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

___ Sitting and reading
___ Sitting quietly after lunch without alcohol
___ Lying down to rest in afternoon
___ Sitting and talking with someone
___ In car stopped in traffic
___ Sitting inactive in public place
___ As a passenger in car <1 hr
___ Watching TV

DIAGNOSTIC ORDERS

☐ **For Oxygen Patients.** Perform HST with four or more channels on current oxygen prescription.

☐ **For Non-Oxygen Patients on Room Air.** Perform HST with four or more channels on room air.

SECONDARY DIAGNOSIS

(Required for PAP delivery if sleep test AHI is between 5 – 14.9)

Please check all applicable:

☐ Excessive daytime sleepiness
☐ Impaired Cognition
☐ Mood Disorders
☐ Insomnia
☐ Hypertension
☐ Ischemic Heart Disease
☐ History of Stroke

SLEEP THERAPY

Face-to-Face Evaluation date _____

If AHI is > 5 based on the ordered home sleep test, please set my patient up on the following PAP equipment:

- E0601 Auto Adjusting CPAP with setting of 4 – 20 cm H_20 with comfort settings
- E0562 Heated Humidifier
- PAP Mask — Patient to choose to comfort (1X3 mos)
- A7035 Headgear (1X6 mos)
- A4604 Tubing w/heating element (1X3 mos)
- A7038 Filter, Disposable (2X1 mo)

Estimated length of need: _____ months

☐ **Opt-Out for PAP order:** Contact me for PAP order after sleep study results are available.

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering a medication for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

Print prescriber's name _____ **NPI #** _____

Prescriber's signature _____ **Date** _____