Local Home Health Provider

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Phone: ______________

Fax: ______________

HST your Way

Clinical Evaluation and Order Form

Customer Support: (877) 337-7111
Web: www.virtuox.net

1 Patient Information:

NAME	GENDER	DOB (mm/dd/yyyy)	SS#
ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL
PREFERRED WRITTEN LANGUAGE		PREFERRED SPOKEN LANGUAGE	
EMERGENCY CONTACT		EMERGENCY PHONE	

2 Prescriber Information:

NAME	ADDRESS	CITY/STATE/ZIP
PHONE	FAX	NPI

3 Insurance:

Does the patient have insurance? ☐ **Yes** ☐ **No**

PAYOR NAME 1	ID #	GROUP #	PHONE
PAYOR NAME 2	ID #	GROUP #	PHONE

4 Sleep History & Physical Exam:

(Fill in the blanks and check all symptoms that apply)

Height: _______ **inches** **Weight:** _______ **lbs** **BMI:** _______ **Neck Size:** _______ **inches** **Sleep Epworth Score:** _______ **(0-24)**

☐ Sleep Disordered Breathing	☐ Loud Snoring	☐ Depression	☐ Insomnia
☐ Oral Appliance Assessment	☐ Non-Restorative Sleep	☐ Gasping/Choking	☐ Observed Apneas
☐ Excessive Daytime Sleepiness	☐ Morning Headaches	☐ Dry Mouth in A.M.	

5 Cardiopulmonary / Upper Airway Exam:

(Check all that apply)

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

6 Diagnostic Codes:

(Check all Diagnosis codes that apply in order to avoid causing a delay in processing the order)

☐ G47.10 Hypersomnia, Unspecified ☐ G47.30 Sleep apnea, Unspecified ☐ G47.33 Obstructive sleep apnea (adult) (pediatric)

7 Home Sleep Test Procedure:

2-night Unattended, Type III Portable Recorder with minimum four (4) channels: Records airflow, respiratory effort, O_2 saturation and heart rate. Performed on room air unless specified below.

☐ **Home Sleep Test on Room Air**	☐ **Home Sleep Test on Oxygen** LPM: _____	☐ **Home Sleep Test with PAP** PAP Pressure: _____ Fixed pressure / No Auto	☐ **Home Sleep Test with Oral Appliance**	☐ **Home Sleep Test with DOT certification**	☐ **Home Sleep Test for pediatric patient ages 12-17**

☐ **Sleep Staging - 2 nights unattended with CPT 95827**

8 Prescriber Signature & Certification:

(Stamped dates/signatures not valid. Must be signed by Prescriber/PA/NP)

I, the undersigned, certify that I am the patient's treating prescriber and that the information contained on this form is based on a face-to-face office visit. I am prescribing a two-night serial HST as medically necessary to validate results because of night to night variability.

Sign Here: X ______________________________ **Date:** ______________

Please fax completed order form & insurance card back to (800) 209-9193