Local Home Health Provider

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Phone: ______________________

Fax: ________________________

VeriSleep Chain of Custody
Home Sleep Test Order Form

Prescription and Clinical Evaluation

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	

2 Physician Information:

NAME	ADDRESS	CITY/STATE/ZIP
PHONE	FAX	NPI

3 Insurance: ☐ Check here if self-pay

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	☐ Observed Apnea
☐ Oral Appliance Assessment	☐ Non-Restorative Sleep	☐ Gasping/Choking	☐ Dry Mouth
☐ Excessive Daytime Sleepiness	☐ Morning Headaches	☐ Dry Mouth in A.M.	

5 Cardiopulmonary / Upper Airway Exam: (Check all that apply)

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

6 Diagnostic Codes:

☐ G47.30 Sleep Apnea, Unspecified	☐ G47.39 Other Sleep Apnea
☐ G47.10 Hypersomnia with Sleep Apnea, Unspecified	☐ R09.02 Hypoxemia
☐ G47.33 Obstructive Sleep Apnea, Adult Pediatric	☐ Other: ______________________

7 Home Sleep Test Procedure:

DOT VeriSleep Home Sleep Test with Chain of Custody wristband

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.

☐ **Test on Oxygen - check here if test is to be performed with patient on current O_2 prescription**

8 Physician Signature & Certification: (Stamped dates/signatures not valid. Must be signed by Physician/PA/NP)

I, the undersigned, certify that I am the patient's treating physician 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 (866) 916-7881

v 5.18.2017