sleeptopia

DON'T IGNORE THE SNORE

Home Sleep Test Order Form

Phone: (833) 256 - 0722

Fax: (888) 510 - 0314

Patient Information

First Name :	Last Name :	MI :	Suffix :	Gender :	DoB (MM/DD/YYYY) :

Prescription RX *(On Room Air unless specified below)*

Home Sleep Test For: ☐ One (1) Night ☐ Two (2) Nights ☐ Three (3) Nights

Other Testing Options: ☐ Dental Appliance ☐ PAP Therapy ☐ Supplemental O2

Diagnosis Codes

- ☐ Excessive Daytime Sleepiness/Fatigue (EDS G47.10)
- ☐ Obstructive Sleep Apnea (G47.33)
- ☐ Witnessed Apneic Events (G47.30)
- ☐ Sleep Apnea, Unspecified (G47.30)
- ☐ Other Additional Codes (Optional): ______________________

To ensure no delay in service, please include:
1. This order form 2. Patient Demographics 3. Chart notes of Visit

Thank you for your Referral!

Physician Information

Dispense as checked/written

Physician Name (First & Last) :	NPI (optional):

Physician Signature :	Date: