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Fax Referral/Order to: 916-482-3467

HOME SLEEP APNEA TEST REFERRAL/ORDER

To better serve you and your patients, please provide the following information:			
PATIENT NAME:	**DOB:**	**Phone Number: ( )**	
Address:	City:	State:	Zip:
Height:	Weight:	BMI:	Age:

Patient's Primary / Secondary Insurance	**Name of Insured (*if not patient*):**	
Primary Insurance Name:	Group #	ID #
Secondary Insurance Name:	Group #	ID #

Ordering Provider:	Address:
Specialty:	City:
Phone:	State: Zip:
Fax [to send patient test results]: ( )	E-mail:

By signing below, I attest that based on my examination of the patient's medical history, there is a high probability of Obstructive Sleep Apnea (OSA). An unattended, Type III, Home Sleep Test with a minimum of 4 channels (airflow, respiratory effort, SpO2 saturation and heart rate), is medically necessary. No co-morbid conditions including, but not limited to: neuromuscular disorders, severe to very severe COPD, CHF w/EF ≤ 45%, supplemental oxygen, moderate to severe pulmonary hypertension with pulmonary artery pressure > 40mmHG, uncontrolled cardiac arrhythmias or cognitive impairment are present that prevent the patient from home sleep testing.

Test Ordered: 1 night, type III, unattended home sleep test.
CPT code: G0399 or 95806

Provider Signature:_____ **Date of Order:** _____

Sleep Symptoms/Clinical Indications (check all that apply)

☐ Witnessed apneas ☐ Habitual snoring ☐ Excessive Daytime Sleepiness (EDS)
☐ Morning headaches ☐ Sleep fragmentation ☐ Epworth Sleepiness Scale ≥10, Score ____/24
☐ Choking / Gasping ☐ Daytime fatigue ☐ Other_____

Complete this section if this is a <u>REPEAT TEST</u>: Prior diagnosis of apnea? ☐ No ☐ Yes (if yes, Test Date:_____)

☐ Weight gain/loss > 10% ☐ Evaluate efficacy ☐ Evaluate need to continue therapy ☐ Prev. inconclusive HSAT
Type of Treatment: ☐ Surgery ☐ Oral Appliance ☐ PAP ☐ Other _____

Fax all required Documentation to: 916-482-3467

In Office Pickup: Upon receipt of the required documentation our sleep coordination team will contact your patient to complete the registration process and schedule a pick up date at our downtown Sacramento/Roseville office anytime between 9am – 4pm.

PULMONARY MEDICINE ASSOCIATES
1508 ALHAMBRA BLVD
SACRAMENTO, CA 95816
916-325-1040

PULMONARY MEDICINE ASSOCIATES
5 MEDICAL PLAZA SUITE 190
ROSEVILLE, CA 95661
916-786-7498

Required Documentation:

1. Completed Home Sleep Apnea Test Referral/Order Form (check all indications that apply, sign and date form.
2. Clinical note/consultation with **relevant medical history** documenting the **indication for home sleep apnea testing** from the patient encounter when the sleep test was ordered.

Additional Information:

1. The ordering provider must complete, sign and date the Home Sleep Apnea Test Referral/Order form.
2. Please mark all clinical indications that apply to your patient on referral/order form.
3. If you are re-testing a patient it is important to indicate the purpose of the retest.
4. All patients will have telephone access to a licensed sleep technologist 24 hours a day.
5. The home sleep apnea test kit includes: step by step visual instructions, URL link to the instructional video, sleep questionnaire (pre and post), patient authorization form and pre-paid postage and packaging materials for return shipment (if shipping to patient's home).
6. Home Sleep Apnea Test (HSAT) has a **15 to 20% false negative rate**. If the Apnea Hypopnea Index (AHI) is low and the patient has complaints of symptoms, they should be referred for an overnight in lab polysomnography (PSG).
7. This is a limited unattended screening for Obstructive Sleep Apnea (OSA). The HSAT is **NOT** used to diagnose:
    a. Central Sleep Apnea or treatment emergent Central Apnea
    b. Narcolepsy
    c. Complex Parasomnias with potential injurious disruptive or violent behavior such as REM Behavior Disorder or Sleep Walking
    d. Periodic Limb Movements
    e. Obesity Hypoventilation Syndrome with $pCO_2 > 45$ mmHg and pO_2 <60 mmHg
    f. Nocturnal seizures