



# HOME SLEEP APNEA TEST REFERRAL/ORDER

To better serve you and your patients, please provide the following information:

<b>PATIENT NAME:</b>	<b>DOB:</b>	<b>Phone Number: (    )</b>	
Address:	City:	State:	Zip:
Height:	Weight:	BMI:	Age:

<b>Patient's Primary / Secondary Insurance</b>	<b>Name of Insured (if not patient):</b>	
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)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Witnessed apneas  | <input type="checkbox"/> Habitual snoring    | <input type="checkbox"/> Excessive Daytime Sleepiness (EDS)          |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Sleep fragmentation | <input type="checkbox"/> Epworth Sleepiness Scale ≥10, Score ____/24 |
| <input type="checkbox"/> Choking / Gasping | <input type="checkbox"/> Daytime fatigue     | <input type="checkbox"/> Other _____                                 |

**Complete this section if this is a REPEAT TEST: Prior diagnosis of apnea?**  No  Yes (if yes, Test Date: \_\_\_\_\_)

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Weight gain/loss > 10% | <input type="checkbox"/> Evaluate efficacy | <input type="checkbox"/> Evaluate need to continue therapy | <input type="checkbox"/> Prev. inconclusive HSAT                  |
| Type of Treatment:                              | <input type="checkbox"/> Surgery           | <input type="checkbox"/> Oral Appliance                    | <input type="checkbox"/> PAP <input type="checkbox"/> Other _____ |

## Fax all required Documentation to 916-482-3647

**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 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<sub>2</sub> > 45 mmHg and pO<sub>2</sub> <60 mmHg
  - f. Nocturnal seizures