Beth Israel Deaconess Hospital
Milton

**Home Sleep Testing oneForm Request**

***please fax completed form with most recent office notes to: 617-796-9099***

## DEMOGRAPHIC INFORMATION

Patient Name: _____ DOB: _____ English Proficient? ☐ Yes ☐ No

Patient Phone Numbers: Mobile #: _____ Home#: _____ Alternate #: _____

Insurance Provider: _____ Insurance ID #: _____

**Has patient had previous testing?** ☐ Yes *(Study report must be submitted if completed at another facility)* ☐ No/Unknown

**If yes, please specify reason for re-testing:** _____

## SLEEP STUDY REQUESTED

☐ **Home Sleep Apnea Test – HSAT** – Unattended Type 3 diagnostic testing. **Indication**: Obstructive Sleep Apnea **Provider:** Neurocare, Inc. (TIN: 043032581)

## PATIENT COMPLAINTS *(select at least one)*

☐ Excessive daytime sleepiness
☐ Disruptive snoring
☐ Frequent arousals/disturbed or restless sleep
☐ Not refreshed or rested after sleepin

## SYMPTOMS *(select at least two)*

☐ Witnessed apneas
☐ Waking up gasping/choking
☐
☐ Enlarged tonsils/physiological abnormalities compromising respiration
☐ Nocturia
☐ Decreased libido
☐ Hypertension
☐ Irritability
☐ Decreased concentration
☐ Memory Loss
☐ Other:

***Duration of Symptoms:**

□ < 2 months □ > 6 months
□ > 2 months □ > 1 year

## DOCUMENTED COMORBIDITIES & MEDICAL HISTORY *(if applicable please fax most recent office notes to 617-796-9099)*

**I acknowledge that the clinical information submitted to support this request is accurate and specific to this patient, and all information has been provided. I authorize submission of this information for precertification on my behalf.**

Ordering Provider Signature: _____ Date: _____

Print Name: _____ NPI: _____