Mass General Brigham

HOME SLEEP APNEA TESTING OneForm Request

fax to: 617-796-9099

Patient Name ________________________________ DOB: ________________ English Proficient? ☐ Yes ☐ No Language:________________

Patient Phone Numbers: Home ____________________________________ Alternate ____

Height ________ Weight _________ BMI _________ Epworth Scale Score ________ Insurance ID#: ____________________________________

☐ Aetna	☐ Cigna	☐ Tufts	☐ Medicare
☐ BCBS	☐ Fallon	☐ United	☐ Medicaid
☐ BCBS PPO/Federal	☐ HPHC	☐ Unicare/GIC	☐ Masshealth-PCP Referral #____________________
☐ BMC	☐ NHP	☐ Other: _____________	

Sleep Study Procedure Requested

☒ **Home Sleep Apnea Test – HSAT** – Unattended Type 3 diagnostic testing. Recommended **ONLY** for patients with high likelihood of Obstructive Sleep Apnea (OSA). **Provider: Neurocare, Inc.** (TIN: 043032581) **Interpreting Provider: Josna Adusumilli, MD**

Indication (Suspected Sleep Disorder)

☒ Obstructive Sleep Apnea (G47.33)

Patient Complaints (*select at least ONE*)

- ☐ Excessive daytime sleepiness
- ☐ Disruptive snoring
- ☐ Irregular breathing/ pauses in breathing during sleep
- ☐ Frequent arousals/disturbed or restless sleep
- ☐ Not refreshed or rested after sleeping
- ☐ Inability to fall asleep/remain asleep
- ☐ Other:

Symptoms* (*select at least TWO*)

- ☐ Wake up gasping/choking
- ☐ Morning headaches
- ☐ Bruxism/teeth grinding during sleep
- ☐ Witnessed apneas
- ☐ Decreased libido
- ☐ Enlarged tonsils/physiologic abnormalities compromising respiration
- ☐ Hypertension
- ☐ Irritability
- ☐ Decreased concentration
- ☐ Memory loss
- ☐ Nocturia
- ☐ Other:

***Duration of Symptoms:**
☐ < 2 months ☐ > 6 months
☐ > 2 months ☐ > 1 year

Other Significant Comorbidities/Medical History

☐ Developmental disability: ____

☐ Mobile/functional disability: ____

Has the patient had previous diagnostic sleep testing? ☐ YES ☐ NO

☐same facility ☐other facility: ____________________ ***(Previous sleep study must be submitted if available)***

If YES, check all boxes that apply:

- ☐ Patient tested negative or inconclusive for OSA within 6 months
- ☐ Retesting due to weight loss of ≥10% body weight
- ☐ Retesting to evaluate outcomes with oral appliance/device
- ☐ Retesting to evaluate outcomes of upper airway surgery
- ☐ Previous diagnostic testing report is unavailable

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 ___________________________

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Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would **never** doze

1 = **slight** chance of dozing

2 = **moderate** chance of dozing

3 = **high** chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place (e.g. a theater or meeting)	
A passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking with someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	

Score Analysis

- **Score of 0-5- you are getting enough sleep**
- **Score of 6-10: you tend to be sleepy during the day; this is the average score**
- **Score of 11-15: you are very sleepy and should seek medical advice**
- **Score of 16 or greater: you are dangerously sleepy and should seek medical advice**

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