

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 sleeping

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: _____