MASSACHUSETTS EYE AND EAR
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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 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: _____