

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_ English Proficient?  Yes  No Language: \_\_\_\_\_

Patient Phone Numbers: Home \_\_\_\_\_ Alternate \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ Epworth Scale Score \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

- |   |                                 |                                       |  |
|---|---------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Aetna            | <input type="checkbox"/> Cigna  | <input type="checkbox"/> Tufts        | <input type="checkbox"/> Medicare                |
| <input type="checkbox"/> BCBS             | <input type="checkbox"/> Fallon | <input type="checkbox"/> United       | <input type="checkbox"/> Medicaid                |
| <input type="checkbox"/> BCBS PPO/Federal | <input type="checkbox"/> HPHC   | <input type="checkbox"/> Unicare/GIC  | <input type="checkbox"/> Masshealth-PCP Referral |
| <input type="checkbox"/> BMC              | <input type="checkbox"/> NHP    | <input type="checkbox"/> 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)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Excessive daytime sleepiness                          | <input type="checkbox"/> Frequent arousals/disturbed or restless sleep | <input type="checkbox"/> Inability to fall asleep/remain asleep |
| <input type="checkbox"/> Disruptive snoring                                    | <input type="checkbox"/> Not refreshed or rested after sleeping        | <input type="checkbox"/> Other:                                 |
| <input type="checkbox"/> Irregular breathing/ pauses in breathing during sleep |  |   |

### Symptoms\* (select at least TWO)

- |  |  |
|--|--|
| <input type="checkbox"/> Wake up gasping/choking   | <input type="checkbox"/> Hypertension            |
| <input type="checkbox"/> Morning headaches   | <input type="checkbox"/> Irritability            |
| <input type="checkbox"/> Bruxism/teeth grinding during sleep                                 | <input type="checkbox"/> Decreased concentration |
| <input type="checkbox"/> Witnessed apneas  | <input type="checkbox"/> Memory loss             |
| <input type="checkbox"/> Decreased libido  | <input type="checkbox"/> Nocturia                |
| <input type="checkbox"/> Enlarged tonsils/physiologic abnormalities compromising respiration | <input type="checkbox"/> Other:                  |

<b>*Duration of Symptoms:</b>	
<input type="checkbox"/> < 2 months	<input type="checkbox"/> > 6 months
<input type="checkbox"/> > 2 months	<input type="checkbox"/> > 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:**

- |  |  |
|--|--|
| <input type="checkbox"/> Patient tested negative or inconclusive for OSA within 6 months | <input type="checkbox"/> Retesting to evaluate outcomes with oral appliance/device |
| <input type="checkbox"/> Retesting due to weight loss of $\geq 10\%$ body weight         | <input type="checkbox"/> Retesting to evaluate outcomes of upper airway surgery    |
|  | <input type="checkbox"/> 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 \_\_\_\_\_

## 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**