

**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: \_\_\_\_\_