VALIULIS SLEEP CLINIC
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Home Sleep Study Order Form

PATIENT INFORMATION

Last name, First name Middle name _____

Address _____

City, State Zip _____

Phone (_____)_____ Cell Phone (____)_____ Email _____

Date of Birth _____

Insurance _____ ID _____

Auth_____

Emergency Contact _____ Phone _____ Email _____

PHYSICIAN INFORMATION

Physician Name: _____

Address:_____

Phone: _____ Fax: _____ email: _____

SLEEP DIAGNOSIS/INDICATIONS for study

(*must check at least one of the following*)

☐ Obstructive Sleep Apnea G47.33
☐ Sleep Apnea, unspecified G47.30
☐ Fatigue R53.83
☐ Snoring G47.8
☐ Hypersomnia, other G47.10
☐ Hypersomnia, unspecified G47.19
☐ Insomnia with Sleep Apnea G47.30
☐ Adjustment Insomnia F51.02
☐ Other Sleep related disorders G47.8
☐ Other_____

MEDICAL HISTORY

Gender: Male / Female Height _____ Weight _____ lbs. BMI_____ Neck circumference _____ in.
☐ Epworth Sleepiness Scale > 8 ☐ STOP-BANG score > 3

In order to program the Embletta home sleep test device, please include the patient's usual sleep times:

Time patient goes to bed _____ Time patient wakes up _____

EXCLUSION CRITERIA (For a home sleep test, none of the following co-morbid conditions can be present.)

☐ Patient does NOT have any of the following diagnoses: Congestive Heart Disease (moderate or severe), Chronic Pulmonary Disease, untreated sleep related movement disorder (PLMD) or immobility/physical limitations.

PHYSICIAN ORDER (please check one)

☐ Sleep Evaluation and Diagnostic Home Sleep Study (95806)
☐ Diagnostic Home Sleep Study (95806)
☐ Sleep Evaluation and Titration Home Sleep Study (95806)
☐ 2 Night Titration Home Sleep Study (95806)

_____ _____ _____/_____/_____

Physician Name (printed) Signature Date

Please fax office notes, demographic information and both sides of the insurance card.

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations?

Circle the appropriate number

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	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place (e.g., a theater or meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch, without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3
Total from above: _____	

YES	NO		**STOP-BANG Sleep Apnea Screening Questionnaire** Does the patient..
		1	**S**nore loudly?
		2	Feel **T**ired, fatigued, or sleepy frequently during the daytime?
		3	**O**bserved breathing stops/pauses during your sleep? or wakes up choking or gasping for breath?
		4	have high blood **P**ressure?
≥ 2 yes answers for questions 1-4: High-risk for Sleep Apnea			
		5	**B**MI >35?
		6	**A**GE over 50 years old?
		7	**N**eck circumference > 15.75 inches (40cm)?
		8	Male **G**ENDER?
		9	Upper-airway structural abnormalities (One or more of the following): small mandible or ‘Overbite”, large tongue, enlarged tonsils, large uvula, small posterior oral airway, Mallampati III or IV.
≥ 1 yes answers for questions 5-9: High-risk for Sleep Apnea			
TOTAL for questions 1-9: If ≥ 2 yes answers then High-risk for Sleep Apnea; If < 2 yes answers: then Low-risk for Sleep Apnea			

PATIENT: Last, First M _____