VIRTUOX

CARDIOSLEEP TESTING
Clinical Evaluation and Order Form

P: (877) 337-7111
F: (888) 635-8380
www.virtuox.net

PRESCRIBER INFORMATION

Name: _____ NPI: _____
Address / City / State / Zip: _____ Phone: _____ Fax: _____
Referral Coordinator: _____ Email: _____

PATIENT INFORMATION

Name: _____ Gender: _____ DOB: (mm/dd/yyyy) _____
Address/City / State / Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Preferred Written / Spoken Language: _____ Emergency Contact / Number: _____
Primary Payer: _____ ID#: _____ Group: _____ Phone: _____
Secondary Payer: _____ ID#: _____ Group: _____ Phone: _____

CLINICAL EVALUATION

Height: _____ Weight: _____ BMI: _____ Neck Size: _____ Sleep Epworth: _____

Related Symptoms: If Applicable

- ○ Excessive Daytime Sleepiness
- ○ Irregular Heartbeat
- ○ Non-Restorative Sleep
- ○ Syncope/Near-Syncope
- ○ Heart Racing
- ○ Shortness of Breath
- ○ Fatigue
- ○ Difficulty Falling/Staying Asleep
- ○ Snoring
- ○ Palpitations
- ○ Observed Apneas
- ○ Other:_____

DURABLE MEDICAL EQUIPMENT COMPANY (DME)

DME Selection (name & location): _____
Address: _____
Phone: _____ Fax: _____

Please **Select a Test Type** and **Diagnosis Code** in the Sections Below **for Each Test Being Ordered**

Sleep Apnea Testing

☐ **Home Sleep Test (HST):**
Room Air up to 2-night unattended portable recorder
with min (4) channels eg: records airflow, respiratory effort, SpO2 / HR

Diagnosis

☐ **Obstructive Sleep Apnea G47.33**
☐ **Hypersomnia G47.10**
☐ **Other:** _____

Other HST Instructions: _____

Ambulatory Cardiac Monitoring

☐ **7 Day Extended Holter Monitoring**
☐ **14 Day Extended Holter Monitoring**
☐ **24-Hour Holter + 7 Day Mobile Cardiac Telemetry**
☐ **24 Hour Holter + 14 Day Mobile Cardiac Telemetry**

Diagnosis

☐ **Bradycardia R00.1**
☐ **Tachycardia R00.0**
☐ **Other:** _____
☐ **Palpitations R00.2**
☐ **Paroxysmal Afib I48.0**

Other ACM Instructions or Duration: _____

If Mobile Cardiac Telemetry (MCT) is ordered but the patient's insurance does not cover MCT or the patient does not meet qualification criteria, please consider this my written order to substitute an Extended Holter. The duration should match the ordered test when possible, up to a maximum of 14 days. I acknowledge that Extended Holter monitoring does not provide notifications during the recording period and events are identified only after data analysis is complete. ☐ *Do Not Substitute Test Type*

I confirm that I have reviewed and agree to the Physician Notification Criteria and the Holter-to-MCT Transition Criteria available at www.virtuox.net/mdn. Other testing options may exist that are not listed on this form. If an alternative test is needed, please contact VirtuOx.

☐ *Check here if the ordering provider will interpret the cardiac testing results. (VirtuOx's panel of cardiologists will interpret if not selected.)*

Prescriber Signature: _____ **Date:** _____

Please fax completed order form, demographics & insurance card to **888-635-8380**

HEADQUARTERS **VirtuOx LLC.**
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