

 Phone: _____
 Fax: _____

HST your Way

Clinical Evaluation and Order Form



Customer Support: (877) 337-7111
 Web: www.virtuox.net

1 Patient Information:

NAME		GENDER		DOB (mm/dd/yyyy)		SS#	
ADDRESS			CITY		STATE		ZIP
HOME PHONE		WORK PHONE		CELL PHONE		EMAIL	
PREFERRED WRITTEN LANGUAGE				PREFERRED SPOKEN LANGUAGE			
EMERGENCY CONTACT				EMERGENCY PHONE			

2 Prescriber Information:

NAME		ADDRESS		CITY / STATE / ZIP	
PHONE		FAX		NPI	

3 Insurance: Does the patient have insurance? Yes No

PAYOR NAME 1		ID #		GROUP #		PHONE	
PAYOR NAME 2		ID #		GROUP #		PHONE	

4 Sleep History & Physical Exam: (Fill in the blanks and check all symptoms that apply)

Height: _____ inches Weight: _____ lbs BMI: _____ Neck Size: _____ inches Sleep Epworth Score: _____ (0-24)

<input type="checkbox"/> Sleep Disordered Breathing	<input type="checkbox"/> Loud Snoring	<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Oral Appliance Assessment	<input type="checkbox"/> Non-Restorative Sleep	<input type="checkbox"/> Gasping/Choking	<input type="checkbox"/> Observed Apneas
<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/> Morning Headaches	<input type="checkbox"/> Dry Mouth in A.M.	

5 Cardiopulmonary / Upper Airway Exam: (Check all that apply)

<input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> Over/Under Bite	<input type="checkbox"/> Crowded Oropharynx	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Teeth Worn	<input type="checkbox"/> Enlarged Tongue	<input type="checkbox"/> Enlarged Tonsils	<input type="checkbox"/> Retrognathia/Micrognathia
<input type="checkbox"/> Maxillomandibular Abnormalities	<input type="checkbox"/> Crowded Hypopharynx	<input type="checkbox"/> Obesity	

6 Diagnostic Codes: (Check all Diagnosis codes that apply in order to avoid causing a delay in processing the order)

G47.10 Hypersomnia, Unspecified G47.30 Sleep apnea, Unspecified G47.33 Obstructive sleep apnea (adult) (pediatric)

7 Home Sleep Test Procedure:

2-night Unattended, Type III Portable Recorder with minimum four (4) channels: Records airflow, respiratory effort, O₂ saturation and heart rate. Performed on room air unless specified below.

<input type="checkbox"/> Comprehensive Home Sleep Test on Room Air and with Sleep Stages*	<input type="checkbox"/> Home Sleep Test on Room Air	<input type="checkbox"/> Home Sleep Test on Oxygen LPM: _____	<input type="checkbox"/> Home Sleep Test with PAP PAP Pressure: _____ Fixed pressure / No Auto	<input type="checkbox"/> Home Sleep Test with Oral Appliance	<input type="checkbox"/> Home Sleep Test with DOT certification	<input type="checkbox"/> Home Sleep Test for pediatric patient ages 12-17
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* Sleep Stages to be calculated by EMG, EOG, EEG. CPT 95827 performed separately via 2-nights with insurance coverage.

8 Prescriber Signature & Certification: (Stamped dates/signatures not valid. Must be signed by Prescriber/PA/NP)

I, the undersigned, certify that I am the patient's treating prescriber and that the information contained on this form is based on a face-to-face office visit. I am prescribing a two-night serial HST as medically necessary to validate results because of night to night variability.

Sign Here: X _____ Date: _____

Please fax completed order form & insurance card back to (800) 209-9193