



**VIRTUOX**

No cost software + low cost oximeters =  
The industry's most cost effective way to qualify oxygen patients!

## Home Sleep Testing Direct Marketing Program

**To make the most out of your new Home Sleep Testing Program we recommend that physicians follow the guidelines below:**

**Visit 1:** Perform a Sleep Epworth test and evaluate for excessive daytime sleepiness on every patient. Schedule all positive Epworth patients for return office visit to complete required "face-to-face" sleep evaluation.

**A Sleep Epworth is considered normal when range is 0-9.**

**Visit 2\*:** Perform sleep H&P; order Home Sleep Test (HST) through VirtuOx. Schedule patient for follow-up visit to review HST results (generally 2 weeks).

**Fax HST Order Form, along with sleep H&P.**

**As part of the HST test results, VirtuOx will provide you with an easy to follow recommendation by a Board Certified Sleep Physician who has interpreted the test.**

**Visit 3\*:** Review HST results. For patients who are positively diagnosed with OSA, discuss condition and treatment with PAP therapy. Order PAP through preferred DME provider. Then schedule patient for required follow-up visit 30-45 days following PAP initiation.

**Visit 4\*:** Complete required "face-to-face" patient evaluation for continuation of PAP therapy.

- Review compliance data from PAP and document patient compliance.
- Document patient's improvement of symptoms as a result of PAP therapy.

**Visits 5+:** Every 6 months - Review patient's sleep prognosis and continuation of PAP therapy.

**\*For these visits, many physicians bill CPT 99214, Level IV office visit with an average Medicare Reimbursement of \$70. Review CMS guidelines for requirements necessary to bill for this code.**

Physicians may still order Home Sleep Tests without performing the recommended office visits at these intervals; however, the face-to-face evaluations prior to ordering the HST and 30 to 45 days following the initiation of PAP therapy are required by CMS and most insurers.

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### 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

<i>Situation</i>	<i>Chance of Dozing</i>
Sitting and reading .....	_____
Watching TV .....	_____
Sitting, inactive, in a public place (e.g., a theater or a meeting) .....	_____
As 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 a lunch without alcohol .....	_____
In a car, while stopped for a few minutes in traffic .....	_____
Total	_____

## Home Sleep Testing Solutions

### Quick Scheduling Guide

*An informative scheduling guide for patients who will be performing a VirtuOx HoST (Home Sleep Test)*

**Dear Home Sleep Test Patient:** Your physician has prescribed a Home Sleep Test from VirtuOx, a Nationwide Sleep Diagnostic Company. For more information about us please visit: [www.VirtuOx.net](http://www.VirtuOx.net) or [www.ApneaBuster.com](http://www.ApneaBuster.com)

**Please call VirtuOx Scheduling at 888-265-6415 Option 1** 24 hours after your physician appointment. Our scheduling department hours are 8:00 AM - 8:00 PM EST. All messages received after hours will be returned the following business day.

**VirtuOx scheduling staff will also attempt to call you!** If we don't hear from you first, we will attempt to call you in order to get your test shipped out! Please respond to messages left immediately by calling 888-265-6415 option 1.

### Frequently Asked Questions

**Who is VirtuOx:** VirtuOx, Inc. is a privately held medical technology channel solutions company that provides diagnostic tools and services to a variety of healthcare organizations and professionals. Our tools assist in diagnosing and treating Respiratory diseases through vertically integrated platforms, products and services.

**What is a Home Sleep Test?** A Home Sleep Test is an easy to perform, two-night non-invasive diagnostic procedure that measures and records breathing interruptions during sleep. This condition is known as Sleep Apnea.

If left untreated, Sleep Apnea can disrupt quality sleep and may cause daytime sleepiness. Sleep Apnea may contribute to high blood pressure, depression, stroke, heart failure, and heart attack.

**What to Expect:** A Virtuox Customer Service Representative will verify insurance and explain benefits, discuss the test procedure, and arrange for shipment of the testing device via USPS 2-day Priority Mail.

The test kit includes: step by step instructions and DVD, sleep questionnaire and patient authorization form, and a pre-paid postage and packaging materials for return shipment. In addition, VirtuOx provides 24 hours technical support.

Once you have completed the test and returned the device, the data will be reviewed and processed within 24 hours by one of our Board Certified Physicians. The results will be sent to your ordering physician for review and follow up treatment.

**Scheduling Guide:** To make the insurance verification, scheduling and testing process most efficient, please follow the steps below: **Please have the following information available and call 1-888-265-6415 option 1.**

1. Mailing Address
2. Date of Birth
3. Insurance Cards (primary and secondary if applicable)

*If your insurance payer requires a Pre Authorization, relax VirtuOx will handle all the paperwork! Please allow up to two weeks for us to obtain this approval.*

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\_\_\_\_\_  
 \_\_\_\_\_  
 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	
REFERRAL COORDINATOR		PHONE		EMAIL	

## 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 \_\_\_\_\_ (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, O<sub>2</sub> 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 / Auto pressure	<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
----------------------------------------------------------------------------------------------	---------------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------------	------------------------------------------------------------------------------

\* 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



**SLEEP HISTORY  
(TO BE COMPLETED BY PATIENT)**

Name: \_\_\_\_\_ Social security number: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse or emergency contact(s): \_\_\_\_\_

Send copy of results to (e.g., family physician, internist): \_\_\_\_\_

**CHIEF COMPLAINT**

**Check any of the following that apply:**

- Loud snoring
- Breathing or snoring stops for brief periods in my sleep
- Awaken gasping for breath
- Do not feel refreshed when I awaken

My MAIN sleep problem has bothered me:

- 1 to 2 years
- longer than 2 years
- several months to 12 months
- within the last 3 months
- within the last month

**I become sleepy during the day (please circle any/all that apply)**

- sitting
- riding
- driving
- reading
- talking
- eating
- standing

**I experience the following:**

- Difficulty falling asleep
- Difficulty remaining asleep
- Awaken too early

**SLEEP TREATMENT**

I was previously diagnosed with:

Sleep apnea When? \_\_\_\_\_ Where? \_\_\_\_\_

My prior treatment included:

- CPAP or BiPAP or Bilevel
- Indicate treatment level (if known) \_\_\_\_\_
- Oral appliance
- Sinus, deviated septum or turbinate reduction
- Uvulopalatopharyngoplasty
- Laser or other procedure on uvula
- Mandibular surgery
- Tonsils and/or adenoidectomy

Restless legs syndrome  
When? \_\_\_\_\_ Where? \_\_\_\_\_ Treatment: \_\_\_\_\_

Periodic limb movements  
When? \_\_\_\_\_ Where? \_\_\_\_\_ Treatment: \_\_\_\_\_

Narcolepsy  
When? \_\_\_\_\_ Where? \_\_\_\_\_ Treatment: \_\_\_\_\_

Insomnia  
When? \_\_\_\_\_ Where? \_\_\_\_\_ Treatment: \_\_\_\_\_



## SYMPTOMS DURING SLEEP

Indicate ON AVERAGE how often you experience the following symptoms especially when sleeping or trying to sleep:

### Times per week

None	1-3	4-6	Daily	Symptom
				My mind races with many thoughts when I try to fall asleep
				I often worry whether or not I will be able to fall asleep
				Fatigue
				Anxiety
				Memory impairment
				Inability to concentrate
				Irritability
				Depression
				Awaken with a dry mouth
				Morning headaches
				Pain which delays or prevents my sleep
				Pain which awakens me from sleep
				Vivid or lifelike visions (people in room, etc) as you fall asleep or wake up
				Inability to move as you are trying to go to sleep or wake up
				Sudden weakness or feel your body go limp when you are angry or excited
				Irresistible urge to move legs or arms
				Creeping or crawling sensation in your legs before falling asleep
				Legs or arms jerking during sleep
				Sleep talking
				Sleep walking
				Nightmares
				Fall out of bed
				Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
				Bed wetting
				Frequent urination disrupting sleep
				Teeth grinding
				Wheezing or cough disrupting sleep
				Sinus trouble, nasal congestion or post-nasal drip interfering with sleep
				Shortness of breath disrupting sleep



**SLEEP HABITS**

Please answer the following questions as accurately as possible. Indicate AM and PM. If your work and/or sleep schedule changes during the week then indicate your schedule using the “shift work” column.

Activity	Usual schedule	Weekends	Shift Work
Lights out			
I usually fall asleep in (minutes, hours)			
How many times do you awaken each night?			
Number of times you have difficulty returning to sleep			
The total time I spend awake in bed			
I usually wake up from sleep at			
What time do you usually get out of bed from sleep?			
How many hours of sleep do you get on average?			
Do you take naps and, if so, for how long?			
Begin work time			
End work time			

If you do rotating shift work, or have other work schedule changes and need more space to describe:

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**MEDICAL HISTORY**

Please check if you have had any of the following:

- ( ) Heart disease List type: (e.g., CHF) \_\_\_\_\_
- ( ) High blood pressure
- ( ) Fibromyalgia
- ( ) Stroke
- ( ) Diabetes
- ( ) Asthma/Emphysema
- ( ) Anxiety
- ( ) Head Injury or brain surgery
- ( ) Depression
- ( ) Reflux
- ( ) Seizures
- ( ) Parkinson’s disease
- ( ) Other \_\_\_\_\_

( ) Pain which disrupts sleep. The typical location(s) for this pain is/are:  
 \_\_\_Headaches      \_\_\_Neck      \_\_\_Back      \_\_\_Chest      \_\_\_Limb (arm(s) or leg(s))  
 \_\_\_Abdominal      \_\_\_Pelvic      \_\_\_Joint (arthritis)

( ) Other medical problems which may affect sleep (please list): \_\_\_\_\_

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**HEIGHT and WEIGHT**

What is your height? \_\_\_\_\_ feet and \_\_\_\_\_ inches  
 What is your weight? \_\_\_\_\_ 1 year ago \_\_\_\_\_ 5 years ago \_\_\_\_\_  
 What is your collar size? \_\_\_\_\_ 1 year ago \_\_\_\_\_ 5 years ago \_\_\_\_\_

**MEDICATION**

Do you take anything to help you sleep? Y/N What? \_\_\_\_\_ How often? \_\_\_\_\_

List current medications and dosages, including both prescriptions and over-the-counter medications:

\_\_\_\_\_  
 \_\_\_\_\_

Are you on supplemental oxygen? Yes \_\_\_ No \_\_\_ If yes, how much? \_\_\_\_\_(Liters/min)

**SOCIAL HISTORY**

Do you smoke? \_\_\_\_\_ Did you previously smoke? \_\_\_\_\_  
 How many years of smoking? \_\_\_\_\_ How much per day? \_\_\_\_\_  
 Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_ drinks per (day/week/month) (please circle)  
 Do you use drugs recreationally? \_\_\_\_\_ If yes, what do you use? \_\_\_\_\_  
 How much caffeinated coffee, tea or cola do you drink daily? \_\_\_\_\_  
 What is your occupation? \_\_\_\_\_  
 What do you usually do at work? \_\_\_\_\_  
 What is your level of education? \_\_\_\_\_

**ENVIRONMENT**

Is your bedroom (loud/quiet) and (light/dark)? (please circle)  
 Is your mattress (soft/hard/just right)? (please circle)  
 Do you go to sleep with the television on? Yes \_\_\_ No \_\_\_  
 Is your sleep disturbed because of your bed partner or others in your household (children or pets)? Yes \_\_\_ No \_\_\_

**FAMILY HISTORY** (Please check all that apply)

Is there a family history of:	Apnea	Snoring	Narcolepsy	Insomnia	Restless Legs Syndrome	Other sleep disturbances
Mother						
Father						
Sister(s)						
Brother(s)						
Grandparent(s)						



## Level 4 Office Visit Interview

Next is a form for an office interview. It can be used as a guideline for the physician or sleep specialist. It can also be used by a nurse or physician's assistant if they see the patient before the physician. This form can be dictated and will qualify as a **level 4** visit if completed and moderate complexity of decision making exam under current Medicare guidelines . It will have the patient's name, account number and the referring physician at the top for dictation purposes.

Next is a small **history** section, which will detail the patient's age, ethnicity and gender, as well as the physician or nurse may circle complaints first, and then the length of complaints and any other complaints which may be present. Under the **complaint** section, it will detail the patient's excessive daytime sleepiness during specific activities.

The next question is whether or not the patient has dry mouth or morning headaches and also if there is evidence of memory loss, concentration problems, attention problems, emotional lability or depression present. At this point the doctor should have a good understanding of whether or not the patient has sleep apnea, narcolepsy or idiopathic hypersomnia and what may be necessary from here is to move through the history into areas which are indicated.

For example, if the patient shows they are having difficulty falling asleep, the next section with psychiatric diagnosis and changes in sleep habits or sleep schedule may be necessary. Also patient's current weight and weight approximately one year ago may be useful for sleep apnea.

Pertinent **past medical history, medication, allergies and social history** are required for a Level 4 examination.

**Family history** will give detailed information regarding apnea, possibility of narcolepsy or insomnia.

**Review of systems** will help explain if patient has idiopathic hypersomnia due to head injury or insomnia due to head injury, and looks for heart burn, chest pain in association with reflux.

**Physical exam** gives a normal vitals and gives an outline **HEENT**. The normal Level 4 exam is indicated on the form if applicable.

Next is an **impression and recommendations** section with a final education section and caution section.

There is a follow-up section and a signature section with a copy sent to referring physician.

This form is used for any initial office interview for sleep patients



## Level IV Office Visit

Name: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Account #: \_\_\_\_\_

**HISTORY:** This is a \_\_\_\_ year old (Caucasian/African-American/Hispanic/Asian) (male/female) who complains of: snoring, gasping for breath, observed apneas, falling asleep at inopportune times, daytime somnolence, nonrestorative sleep, nightmares, night sweats, night terrors, cataplexy, hypnogogic hallucinations, sleep paralysis, leg restlessness, sleep onset insomnia, sleep maintenance insomnia, or early morning awakening insomnia for \_\_\_\_ (years/months) and \_\_\_\_\_. These symptoms have persisted and have (progressed, continued, remained unchanged, improved) since being first noticed. Bed partners (have/have not) observed apnea and/or loud snoring.

**COMPLAINT:** The Pt complains of excessive daytime somnolence when he/she is \_\_\_\_\_ (reading, watching TV, sitting quietly, riding in a car, talking, watching a movie or \_\_\_\_\_) and has been sent to us for further evaluation.

Pt will (occasionally, frequently, never) awaken with dry mouth and (occasionally, frequently, never) has morning headaches. There is also the presence of: OR there is no evidence for:

Memory loss, Lack of concentration, Attention problems, Emotional lability Depression

Pt has a previous psychiatric diagnosis of \_\_\_\_\_ which is currently controlled with \_\_\_\_\_.

Pt's current weight is \_\_\_\_\_, and 1 year ago he/she weighed \_\_\_\_\_.

Pt reports that there have been (no, some) changes in their sleep habits or patterns. [These changes include] Pt reports that their bedroom is (noisy, quiet) (light, dark), and that they (share a bed, sleep alone). In addition they report that their mattress is (hard, soft, comfortable, uncomfortable). Pt reports: (watching TV in bed, reading in bed, watching the clock all night long, excessive rumination or \_\_\_\_\_).

The patient enters bed at \_\_\_\_\_, falls asleep within \_\_\_\_\_ minutes, and awakens \_\_\_\_\_ times an evening. These awakenings are \_\_\_\_\_ (spontaneous, to go to the bathroom, from nightmares, tossing and turning, or \_\_\_\_\_). The patient wakes at \_\_\_\_\_ during the week and \_\_\_\_\_ on the weekends. The patient reports taking \_\_\_\_\_ naps a day for \_\_\_\_\_ minutes.

**PAST MEDICAL HISTORY:** Pt has a past medical history for:

\_\_\_\_ prior dx of \_\_\_\_ OSA \_\_\_\_ narcolepsy \_\_\_\_ restless legs \_\_\_\_ previous tonsillectomy \_\_\_\_ adenoidectomy \_\_\_\_ previous \_\_\_\_ UPPP \_\_\_\_ hx of a psychiatric disorder \_\_\_\_ neurological disorder (seizures, head injury, enuresis) \_\_\_\_ diabetes \_\_\_\_ hypertension \_\_\_\_ thyroid disease. Other \_\_\_\_\_.

**MEDICATIONS:** Current medications include (none):

**ALLERGIES:** \_\_\_\_\_, NKDA

**SOCIAL HISTORY:** Pt (is/was) employed as a \_\_\_\_\_ for \_\_\_\_\_ years. He/she is currently (married/divorced/single/widowed) with \_\_\_\_\_ children ages \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_. Pt reports smoking \_\_\_\_\_ packs a day for \_\_\_\_\_ years [Pt is a nonsmoker]. Pt reports drinking \_\_\_\_\_ oz of \_\_\_\_\_/day for \_\_\_\_\_ years [Pt is a nondrinker] [Pt is a social drinker]. Pt reports using \_\_\_\_\_ drugs on a \_\_\_\_\_ basis for \_\_\_\_\_ years. [Pt does not take drugs recreationally]. Pt reports drinking \_\_\_\_\_ cups of caffeinated beverages a day.

**FAMILY HISTORY:** Pt reports

Mother with a history of (OSA, narc, insomnia, parasomnias, RLS, snoring \_\_\_\_\_)

Father with a history of (OSA, narc, insomnia, parasomnias, RLS, snoring \_\_\_\_\_)

Sister(s) with a history of (OSA, narc, insomnia, parasomnias, RLS, snoring \_\_\_\_\_)

Brother(s) with history of (OSA, narc, insomnia, parasomnias, RLS, snoring \_\_\_\_\_)

[No family history of a sleep disorder or problem]

**REVIEW OF SYSTEMS:** Pt was negative except as noted above OR Pt reported further symptomatology including: previous head injury (if yes, explain \_\_\_\_\_) Heartburn Y/N Chest pain Y/N Sour brash Y/N Cough Y/N Hiatal hernia Y/N Bruxism N/Y

**PHYSICAL EXAM:** Comfortable appearing (obese/thin/normal) (man/woman) in no distress.

Pulse \_\_\_\_\_ Blood pressure \_\_\_\_\_ Respiration \_\_\_\_\_ Temp \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI: \_\_\_\_\_

O<sub>2</sub> sat on room air \_\_\_\_ Neck size: \_\_\_\_\_

Mallampati classification: 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_

**HEENT:** Sinuses nontender. Nares (clear/obstructed/narrow). Turbinates (normal/enlarged). Oropharynx with (good dentition, overbite, under bite, normal teeth alignment). Pt had a(n) (enlarged, elongated, reddened) uvula, with (normal amounts, extra) webbing surrounding the oropharyngeal orifice. Soft palate had a (normal, shallow, steep) slope. (Normal enlarged, large, long) tongue and (normal enlarged, large, long) tonsillar pillars. There appeared to be (some crowding, enough room) within the posterior airway space (PAS). The doctor was (able, unable, only able with a tongue blade) to view the PAS. Neck was (short, normal) and supple without mass, thyromegaly, JVD. Pt showed (no/some/extreme) retrognathism/micrognathia. Lymphatic: no cervical or supraclavicular adenopathy.

**LUNGS:** Clear to auscultation and percussion. Good air movement. Normal expansion and effort.

**CARDIAC EXAM:** Normal PMI. No murmurs, rubs, gallops, rhythm is regular

**ABDOMEN:** Soft, nontender, active bowel sounds. No organomegaly.

**EXTREMITIES:** No clubbing, cyanosis or edema.

**NEURO EXAM:** Alert, oriented. Cranial nerves 2-12 intact. Normal gait. Normal motor. Deep tendon reflex 2+ bilaterally.

**IMPRESSION:** Due to the patient's co-morbid conditions: Diabetes mellitus type1/2, Hypertension, Coronary heart disease, Congestive heart failure, Obesity, COPD, Drug resistant hypertension, Atrial Fib, Angina\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ and \_\_\_\_\_, he/she appears a likely diagnosis for (RLS, apnea, narcolepsy, insomnia, \_\_\_\_\_). Pt is not likely to have (RLS, apnea, narcolepsy, insomnia, \_\_\_\_\_).

**RECOMMENDATION:** Patient was recommended for (Home Sleep Test, full nighttime polysomnography, split night, CPAP titration, MSLT, overnight oximetry, pH and motility study, sleep diary, TFT, TSH, HLA, sleep hygiene education, stimulus control therapy, \_\_\_\_\_.)

**New Paragraph**

Pt was educated on the pathophysiology behind the diagnosis, possible methods of treatment, possible medical testing procedures. Pt reports understanding the diagnosis and methods explained and (agrees/disagrees) to a (HST, PSG, MSLT, split night, CPAP titration, overnight oximetry, pH and motility study, sleep diary, TFT, HLA, sleep hygiene education, stimulus control therapy, chronotherapy, medication, or \_\_\_\_\_). Patient (was/was not) cautioned about operating machinery due to sleepiness, driving to the caution statement about operation machinery

I will have the pt follow-up with me in \_\_\_\_\_ weeks after the sleep study. At this time I will make treatment recommendations.

I spent \_\_\_\_\_ minutes with this patient.

\_\_\_\_\_

Please send copies to Dr. \_\_\_\_\_ and the sleep lab.



## Follow-up Office Visits

The next form is a follow-up office visit. This also has the patient's name, account number and referring physician. It goes back through the chief complaints, then gives an expanded problem focused history which lists the age, ethnicity and sex and previous diagnosis of the patient.

No. 1 represents apnea; for example, how long the patient has been wearing CPAP and if they've been having any difficulty. The physician simply circles the issues to address in the recommendations section. No. 2 represents insufficient sleep and poor sleep hygiene, recording the number of total hours it takes to fall asleep, which can be filled out for any diagnosis. No. 3 represents insomnia looking at sleep restriction, stimulus control, and other behavioral techniques. No. 4 looks at individuals with narcolepsy or idiopathic hypersomnia, the medication they are taking and side effects and/or behavioral naps being used. No. 5 looks at limb movements and medications which may be used as well.

There is then a review of systems section and then a current **review of systems** statement required for any Level 3 exam. There is then **expanded problem focused physical exam**, which includes vitals and a quick overview HEENT. There is a **laboratory results** section with a **patient understanding** results that have been explained section.

Next is physician **impression** and **recommendations** with axis. The time spent with patient shows that if the doctor has been with them 25 minutes this can be a Level 4 exam; 15 minutes, a Level 3 exam; and 10 minutes, a Level 2 exam. It is then signed, cc'd to referring doctor and dictated doctor.

If you have a Ph.D. performing these exams, the bottom line, "patient was discussed in detail with me," needs to be added and signed off on by an M.D.



## Follow-up Office Visit

Name:

Account #:

Referring Physician:

### Chief Complaint

The patient has previous complaints of (loud snoring, observed apneas, excessive daytime somnolence, fatigue, am headaches, falling asleep at inopportune times, non-restorative sleep, nightmares, night sweats, night terrors, cataplexy, hypnogogic hallucinations, sleep paralysis, leg restlessness, sleep onset insomnia, sleep maintenance insomnia, early awakening insomnia and

### Expanded Problem Focused History

This is a \_\_\_\_\_ year old (Caucasian/African-American/Hispanic/Asian) (male/female) who has a previous diagnosis of (OSA, CSA, Narcolepsy, RLS, PLMS, Psychophysiological Insomnia or \_\_\_\_\_)

### For OSA

- 1) Pt has been wearing CPAP/BiPAP for the past \_\_\_\_\_ (months/weeks) and reports (tolerating it well, poor tolerance, nasal dryness, congestion, recurrent sinus infections, constant air leaks, difficulty wearing the mask all evening, claustrophobia, fatigue, continued excessive daytime somnolence, headache, difficulty initiating or maintaining sleep, dry mouth, non-restorative sleep, feeling less sleepy or – ANYTHING NEW GOES HERE. INCLUDE SEVERITY, QUALITY AND DURATION

### For Insufficient Sleep

- 2) Pt has been getting \_\_\_\_\_ hours of sleep and following appropriate sleep hygiene and is now sleeping on a more regular schedule.

### For Insomnia

- 3) Pt has been working on sleep restriction (in bed only \_\_\_\_\_ hours), cognitive distortions (no longer thinks \_\_\_\_\_), and stimulus control (only sleeping and sex in bed).

### For Narcolepsy

- 4) Pt has been following the treatment regiment of \_\_\_\_\_ at \_\_\_\_\_ mg \_\_\_\_\_ times a day, behavioral naps, and reports: continued sleepiness, feeling better, headaches, jittery feelings, palpitations, nausea, dizziness, no side effects – ANY OTHER DRUG SYMPTOMS

### For Limb Movements

- 5) Pt has been following the treatment regimen of \_\_\_\_\_ at \_\_\_\_\_ mg \_\_\_\_\_ times a day and reports that his/her limb movements have (remained the same, decreased, resurfaced, worsened) and has had the following side effects: (nausea, dizziness, dry mouth, GI disturbances, Palpitations, \_\_\_\_\_)

### Problem Pertinent Review of Systems:

- 5) Review of systems unchanged since \_\_\_\_\_ (date of last visit). Except: EDS, tolerating CPAP well, poor tolerance to nasal CPAP, nasal dryness, congestion, recurrent sinus infections, constant air leaks, difficulty wearing the mask all evening, claustrophobia, continued excessive daytime somnolence, headache, difficulty initiating or maintaining sleep, dry mouth, non-restorative sleep or – ANYTHING NEW GOES HERE

I have reviewed the complete review of systems, complete past, complete family, and complete social history, medications and allergies, and they are documented in the chart. OR Pt is currently a shift worker, has a new job schedule, is experiencing a new stressor, e.g., death in family, marital problems, depression, anxiety, new job, moving, marriage,

**Expanded Problem Focused Physical Exam:** Comfortable appearing (obese/thin/normal) (man/woman) in no distress.

Pulse \_\_\_\_\_ Blood pressure \_\_\_\_\_ Respiration \_\_\_\_\_ Temp \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI: \_\_\_\_\_

O2 sat on room air \_\_\_\_ Neck size: \_\_\_\_\_ Mallampati classification: 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4 \_\_\_\_

**HEENT:** Sinuses nontender. Nares (clear/obstructed/narrow). Turbinates (normal/enlarged). Oropharynx with (good dentition, overbite, under bite, normal teeth alignment). Pt had a(n) (enlarged, elongated, reddened) uvula, with (normal amounts, extra) webbing surrounding the oropharyngeal orifice. Soft palate had a (normal, shallow, steep) slope. (Normal enlarged, large, long) tongue and (normal enlarged, large, long) tonsillar pillars. There appeared to be (some crowding, enough room) within the posterior airway space (PAS). The doctor was (able, unable, only able with a tongue blade) to view the PAS. Neck was (short, normal) and supple without mass, thyromegaly, JVD. Pt showed (no/some/extreme) retrognathism/micrognathia. Lymphatic: no cervical or supraclavicular adenopathy.

**LUNGS:** Clear to auscultation and percussion. Good air movement. Normal expansion and effort.

**CARDIAC EXAM:** Normal PMI. No murmurs, rubs, gallops, **rhythm is regular**

**ABDOMEN:** Soft, nontender, active bowel sounds. No organomegaly.

**EXTREMITIES:** No clubbing, cyanosis or edema.

**NEURO EXAM:** Alert, oriented. Cranial nerves 2-12 intact. Normal gait. Normal motor. Deep tendon reflex 2+ bilaterally.

### Laboratory Results

**If Previous Sleep Study:** On \_\_\_\_\_ a (PSG, CPAP Titration, or Split Night) was performed. It was discovered that this patient:

**For PSG FOLLOW-UP:** had (an overall RDI of \_\_\_\_\_, \_\_\_\_\_ Apneas and \_\_\_\_\_ Hypopneas, with an oxygen desaturation of \_\_\_\_\_). (IF PLMS \_\_\_\_\_ leg movements, with a leg movement index of \_\_\_\_\_, and a PLM Arousal index of \_\_\_\_\_). If **MSLT:** Multiple Sleep Latency Test as performed the results indicated that the patient had \_\_\_\_\_ rest opportunities, falling asleep \_\_\_\_\_ times, for an overall average sleep onset latency of \_\_\_\_\_, and \_\_\_\_\_ number of REM periods with a REM onset latency of \_\_\_\_\_. **REPORT SOREMS IF NECESSARY.**

For **CPAP Follow-up:** performed well (or did not tolerate) CPAP with a new RDI of \_\_\_\_\_ at a pressure of \_\_\_\_\_ cm. This patient (did or did not) require O<sub>2</sub>, wedge or chin strap. (IF PLMS \_\_\_\_\_ leg movements, with a leg movement index of \_\_\_\_\_, and a PLM Arousal index of \_\_\_\_\_.)

Pt (and spouse, relative, friend) report(s) understanding these results as I have explained them.

### Impression:

After some discussion with Mr./Mrs. \_\_\_\_\_ it was determined that they had Severe/Moderate/Mild (OSA, Narcolepsy, Excessive Hypersomnolence, Insufficient Sleep, PLMS, Insomnia)

or \_\_\_\_\_

AND

- \_\_\_\_\_ They would be interested in Nasal CPAP
- \_\_\_\_\_ They would continue with sleep logs and the behavioral treatments, including sleep restriction, stimulus control
- \_\_\_\_\_ Pt will remain on Permax, Mirapex, Requip, Sinemet, or Klonipin @ \_\_\_\_\_ mg.
- \_\_\_\_\_ They would begin a regimen of behavioral naps and Methylphenidate, Cylert, or Provigil @ \_\_\_\_\_ mg.
- \_\_\_\_\_ They would continue with nasal CPAP at \_\_\_\_\_ cm, with humidifier, wedge, chin strap
- \_\_\_\_\_ They would increase their total sleep time to \_\_\_\_\_ and regularize their sleep schedule
- \_\_\_\_\_ They would need to use ancillary methods to increase comfort of CPAP; i.e., KY Jelly, moleskin, heating pad
- \_\_\_\_\_ Pt required an increase/decrease of CPAP pressure from \_\_\_\_\_ to \_\_\_\_\_ due to (weight gain, weight loss, pt feels they are not getting enough air, etc.)

In addition, we discussed the severity of his/her diagnosis and other possible treatments including: site directed surgeries such as (a Tracheostomy, Bimaxillary advancement, Somnoplasty, UPPP, Hyoid advancement, Glossopharyngeal advancement).

Yes/No Counseled regarding driving or operating machinery due to sleepiness.

Patient's CPAP machine pressure was checked in the office today. Yes/No If yes, pressure was correct. Yes/No

**Recommendation/Plan** continue previous plan, follow-up in \_\_\_\_\_ months OR

AXIS I

AXIS II Follow-up visit

AXIS III

**Time Spent with Patient** \_\_\_\_\_ > \_\_\_\_\_ % of this was spent in counseling (25 = 4, 15 = 3, 10 = 2)

Signed: \_\_\_\_\_

Cc: Referring Doctor

Dictated by: \_\_\_\_\_

This patient was discussed in detail with me. The medical record as stated above reflects my active participation in and management of the course of treatment.