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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Coral Springs, FL. 33076
Phone: 877.337.7111
Fax: 866.677.4465

Virtuox Laboratory
2677 North East 103rd St. #111
Aventura, FL 33180
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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

Situation	*Chance of Dozing*
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 or 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 Physic ians. 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.

VirtuOx Corporate
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Suite 304
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Phone: 954.344.7075
Fax: 866.215.7347

VirtuOx Laboratory
1001 Bayhill Drive
Second Floor
San Bruno, CA 94006
Phone: 877.337.7111
Fax: 866.215.7347

Local Respiratory Provider

Nation Wide Independent Diagnostic Testing Facility

Phone: 877-337-7111 Fax: 866-215-7347

Home Sleep Test (HoST) Order Form

Patient Demographics:

First Name: _____ Last Name: _____ Sex: _____ DOB: _____ mm/dd/yyyy

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Email: _____

Preferred Language Written: _____ Preferred Language Spoke: _____

Insurance Demographics: *(*Copies of Private Insurance cards must be faxed for all non Medicare referrals)*

Payer name 1: _____ ID#: _____ Group #: _____ Phone: _____

Payer name 2: _____ ID#: _____ Group #: _____ Phone: _____

Referring Physician Demographics:

Physician Name: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email _____

Designates all required Insurance fields ** Please document all aspects of this form into your normal charting format*

Sleep History & Physical: *(*Must have at least one checked off)*

- ☐ **Sleep disordered breathing**
- ☐ **Observed apnea**
- ☐ **Non-restorative sleep**
- ☐ **Loud snoring**
- ☐ **Morning headaches**
- ☐ **Morning dry mouth**
- ☐ **Excessive daytime somnolence**
- ☐ **Awakening gasping for breath**
- ☐ **Depression**

Focused Cardiopulmonary / Upper Airway Exam: *(*Must have at least one checked off)*

- ☐ **Nasal Obstruction**
- ☐ **Teeth Worn**
- ☐ **Maxillomandibular Abnormalities**
- ☐ **Over / Under Bite**
- ☐ **Enlarged Tongue**
- ☐ **Crowded Hypopharynx**
- ☐ **Hypertension**
- ☐ **Enlarged Tonsils**
- ☐ **Obesity**
- ☐ **Crowded Oropharynx**
- ☐ **Retrognathia / Micrognathia**
- ☐ **Performed but N / A**

Physical Exam: *(BMI and Neck Circumference are required)*

Height: _____ inches Weight: _____ lbs BMI: _____ Neck Circumference: _____

Sleep Epworth Exam: *(*Please rate patient's rate of dozing)*

Epworth Number: _____

0= No chance on dozing	***1= Slight chance of dozing***	***2= Moderate chance of dozing***	***3= High chance of dozing***
____ Sitting & Reading	____ Lying down to rest in afternoon	____ In car stopped in traffic	____ As a passenger in car <1 hr
____ Sitting quietly after lunch w/o alcohol	____ Sitting & talking with someone	____ Sitting inactive in public place	____ Watching TV

Diagnostic Orders:

Diagnosis: ☐ Hypoxemia ☐ Unspecified Sleep Apnea ☐ Insomnia with OSA ☐ Obstructive Sleep Apnea ☐ Other: _____

➡ ☐ **For Oxygen patients**

Perform a 2 night HST with four or more channels on current Oxygen Prescription

Monitors and records a minimum of four (4) channels: respiratory movement/effort, airflow, ECG/heart rate and oxygen saturation

➡ ☐ **For Non Oxygen patients On Room Air**

Perform a 2 night HST with four or more channels on room air

Monitors and records a minimum of four (4) channels: respiratory movement/effort, airflow, ECG/heart rate and oxygen saturation

I am the patients treating physician and I have filled this prescription based upon a face to face office visit. I am prescribing a two night serial HST is medically necessary to validate results because of night to night variability.

Physician Signature: **Date:**

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

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

____sitting
____riding
____driving
____ reading
____talking
____eating
____standing

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 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:

MEDICAL HISTORY

Please check if you have had any of the following:

( ) Heart disease List type: (e.g., CHF)_____ ( ) Diabetes ( ) Depression
( ) High blood pressure ( ) Asthma/Emphysema ( ) Reflux ( ) Thyroid condition
( ) Fibromyalgia ( ) Anxiety ( ) Seizures ( ) Parkinson's disease
( ) Stroke ( ) Head Injury or brain surgery ( ) 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):_____

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 l**eve**l 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: _____
02 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 surrunding 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) retrognathis/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, Atril 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, pssible 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: _____
02 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 surrunding 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) retrognathis/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 O2, 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.