Local Home Health Provider

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Phone: ______________

Fax: ______________

VirtuSOM Program
Overnight EEG Order Form
Prescription and Clinical Evaluation

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: ☐ Check here if self-pay

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

4 Sleep History & Physical Exam: (check all conditions that could be impacting sleep quality)

Comorbidities:	☐ Insomnia ☐ Hypertension	☐ Diabetes ☐ Morbidly obese	☐ Depression ☐ Anxiety	☐ TBI ☐ PTSD
Currently prescribed:	☐ Benzodiazepine ☐ Anticonvulsant	☐ Other sleeping aid ☐ Opioid	☐ Antidepressant ☐ Nerve pain	☐ Antianxiety ☐ CNS stimulant

5 Diagnostic Codes:

Hyposomnia / Insomnia
- ☐ F51.03 Paradoxical insomnia
- ☐ F51.09 Other insomnia not due to a substance or known physiological condition
- ☐ G47.00 Insomnia, unspecified

Hypersomnia
- ☐ G47.11 Idiopathic hypersomnia with long sleep time
- ☐ R53.83 Other Fatigue
- ☐ G47.8 Other Sleep Disorders

Hypersomnia with comorbid depression
- ☐ F51.12 Insufficient Sleep Syndrome
- ☐ F51.19 Hypersomnia

Sleep quality potentially impacted by mental state
- ☐ F41.9 Anxiety disorder, unspecified

Memory potentially impacted by sleep quality
- ☐ G31.84 Mild cognitive impairment

6 VirtuSOM Overnight EEG Test Procedure:

☐ Medication Validation Program

Used to verify patients need for sleep medications prior to prescribing

Night 1 EEG

Auto Enroll in CBT-I if recommended

Auto Repeat EEG for 1 night after CBT-I

☐ Medication Titration Program

Used to verify the lowest dosage required to obtain optimum sleep

Medication: ______________

Night 1 EEG & dosage: ______________

Night 2 EEG & dosage: ______________

Night 3 EEG & dosage: ______________

☐ Medication Elimination Program

Used to eliminate sleep medications and replace with CBT-I the gold standard for Insomnia

Medication: ______________

Night 1 EEG & dosage: ______________

Night 2 EEG & dosage: ______________

Night 3 EEG & dosage: ______________

Auto Enroll in CBT-I if recommended

Auto Repeat EEG for 1 night after CBT-I

7 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 up to a three-night overnight EEG to assess sleep quality, conduct sleep medication titration or assess the need for sleep medications.

Sign Here: X ______________________________ **Date:** ______________

Please fax completed order form & insurance card back to (866) 912-2631

v 11.16.2018