

Local Home Health Provider

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)	
ADDRESS		CITY		STATE	
HOME PHONE		WORK PHONE		CELL PHONE	
HOME PHONE		WORK PHONE		EMAIL	
PREFERRED WRITTEN LANGUAGE			PREFERRED SPOKEN LANGUAGE		
EMERGENCY CONTACT			EMERGENCY PHONE		

2 Insurance: Check here if self-pay

PRIMARY PAYER	ID #	GROUP #	PHONE
SECONDARY PAYER	ID #	GROUP #	PHONE

3 Prescriber Information:

NAME	ADDRESS	CITY / STATE / ZIP
PHONE	FAX	NPI
REFERRAL COORDINATOR	PHONE	EMAIL

4 Sleep History: (Check all conditions that could be impacting sleep quality)

Comorbidities:	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression	<input type="checkbox"/> TBI
	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Morbidly obese	<input type="checkbox"/> Anxiety	<input type="checkbox"/> PTSD
Currently prescribed:	<input type="checkbox"/> Benzodiazepine	<input type="checkbox"/> Other sleeping aid	<input type="checkbox"/> Antidepressant	<input type="checkbox"/> Antianxiety
	<input type="checkbox"/> Anticonvulsant	<input type="checkbox"/> Opioid	<input type="checkbox"/> Nerve pain	<input type="checkbox"/> CNS stimulant

5 Diagnostic Codes: (Check all ICD-10 codes that apply)

Hyposomnia / Insomnia <input type="checkbox"/> F51.03 Paradoxical insomnia <input type="checkbox"/> F51.09 Other insomnia not due to a substance or known physiological condition <input type="checkbox"/> G47.00 Insomnia, unspecified Hypersomnia <input type="checkbox"/> G47.11 Idiopathic hypersomnia with long sleep time <input type="checkbox"/> R53.83 Other Fatigue <input type="checkbox"/> G47.8 Other Sleep Disorders	Hypersomnia with comorbid depression <input type="checkbox"/> F51.12 Insufficient Sleep Syndrome <input type="checkbox"/> F51.19 Hypersomnia Sleep quality potentially impacted by mental state <input type="checkbox"/> F41.9 Anxiety disorder, unspecified Memory potentially impacted by sleep quality <input type="checkbox"/> G31.84 Mild cognitive impairment
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6 VirtuSOM Overnight EEG Test Procedure:

<input type="checkbox"/> Medication Validation Program <i>Used to verify patients need for sleep medications prior to prescribing</i> Night 1 EEG Auto Enroll in CBT-I if recommended Auto Repeat EEG for 1 night after CBT-I	<input type="checkbox"/> Medication Titration Program <i>Used to verify the lowest dosage required to obtain optimum sleep</i> Medication: _____ Night 1 EEG & dosage: _____ Night 2 EEG & dosage: _____ Night 3 EEG & dosage: _____	<input type="checkbox"/> Medication Elimination Program <i>Used to eliminate sleep medications and replace with CBT-I the gold standard for Insomnia</i> 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
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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: _____ Date: _____

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