HST Quick Script - Sleep Study Recommendation

Fax this form and face sheet to: 614-842-2467

PATIENT NAME: _____ PHONE: _____ DOB: _____

ADDRESS: _____ Ht: _____ Wt: _____

☐ Copy of demographic info? Yes No ☐ Copy of insurance info? Yes No

☐ Home Sleep Study	☐ PSG Study – In Lab

Sleep Evaluation Findings:

_____

_____

_____

_____

Chief Complaint / Diagnosis: (Check all that appy)

☐ Upper Airway Soft Tissue Abnormalities	☐ Excessive Daytime Sleepiness (Hypersomnia)
☐ History of Heart Disease	☐ Insomnia
☐ Craniofacial abnormalities	☐ Witnessed Apnea
☐ Mood Disorder	☐ Snoring
☐ History of Stoke	☐ Documented Hypertension
☐ Gasping, choking or stops breathing during sleep	

Check all that apply:

☐ Individual has severe clinical systems highly suspicious of obstructive sleep apnea, where initiation of treatment is felt to be urgent and standard polysomnography is not readily available.

☐ Follow-up after initial therapy has begun to evaluate the continued need for CPAP therapy.

By signing below, this validates the prescription above and indicates that the patient has been informed that DASCO/CPAP Central will contact them regarding this referral. Please insure that clinical notes are in the patient's file documenting the initial need for this equipment.

X_____ _____/_____/_____

Physician's Handwritten/Electronic Signature Date

_____

Physician's Printed Name NPI# Phone