**Local Home Health Provider**
Affordable Medical Supplies
501 W. Kingshighway
Paragould, AR 72450
Phone: 870-239-0997
Fax: 870-239-9037

# HST your Way

Clinical Evaluation and Order Form

VIRTUOX

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 Score: _____ (0-24)**

| | | | |
|---|---|---|---|
| ☐ Sleep Disordered Breathing | ☐ Loud Snoring | ☐ Depression | ☐ Insomnia |
| ☐ Oral Appliance Assessment | ☐ Non-Restorative Sleep | ☐ Gasping / Choking | ☐ Observed Apneas |
| ☐ Excessive Daytime Sleepiness | ☐ Morning Headaches | ☐ Dry Mouth in A.M. | |

## 5 Cardiopulmonary / Upper Airway Exam: (Check all that apply)

| | | | |
|---|---|---|---|
| ☐ Nasal Obstruction | ☐ Over / Under Bite | ☐ Crowded Oropharynx | ☐ Hypertension |
| ☐ Teeth Worn | ☐ Enlarged Tongue | ☐ Enlarged Tonsils | ☐ Retrognathia / Micrognathia |
| ☐ Maxillomandibular Abnormalities | ☐ Crowded Hypopharynx | ☐ 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, $O_2$ saturation and heart rate. Performed on room air unless specified below.**

| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|---|---|
| **Comprehensive Home Sleep Test on Room Air and with Sleep Stages*** | **Home Sleep Test on Room Air** | **Home Sleep Test on Oxygen** LPM: _____ | **Home Sleep Test with PAP** PAP Pressure: _____ Fixed / Auto pressure | **Home Sleep Test with Oral Appliance** | **Home Sleep Test with DOT certification** | **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**