theREALsleep

Real results, Real solutions, REALsleep

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Rx for Home Sleep Test

Patient Name:_____ Referring Physician Name:_____

DOB: _____ License:_____

Phone: _____ NPI: _____

Email: _____ Phone:_____

Address: _____ Email: _____

Insurance Provider: _____ Office Name: _____

Insurance Policy Number: _____ Address: _____

Insurance Phone Number:_____ Office Tax ID: _____

Insurance Group ID: _____ Office NPI: _____

SLEEP HISTORY & PRESENTING SYMPTOMS:

- ☐ Snoring
- ☐ Witnessed Apnea
- ☐ Morning Headaches
- ☐ Nocturia
- ☐ Daytime Sleepiness
- ☐ Fatigue
- ☐ Congestive Heart Failure
- ☐ Nocturnal Awakenings
- ☐ Impaired Cognition
- ☐ Diabetes
- ☐ Insomnia
- ☐ Non-Restorative Sleep
- ☐ Bruxism
- ☐ Restless Leg / Periodic Limb Movements
- ☐ Central Sleep Apnea
- ☐ Stroke
- ☐ Hypertension
- ☐ Obesity (BMI:_____)
- ☐ CPAP Intolerant
- ☐ Other Symptoms:

  _____

SUSPECTED DIAGNOSIS:

☐ R/O Sleep Apnea	G47.33
☐ Treat OSA	G47.33
☐ Treat CSA	G47.31
☐ Treat Complex SA	G47.31
☐ Re-Titration for OSA	G47.33
☐ R/O	G47.61
☐ R/O Narcolepsy	G47.419
☐ Restless Leg Syndrome	G25.81
☐ Snoring	R06.83
☐ Other: _____	

- ☐ Testing Consultation & Treatment Management
- ☐ Oral Appliance *CPT: E0486*

(Once the study is completed, theREALsleep will review the results with the patient at a consultation appointment after the study. Initiation of treatment and on-going management by Board-Certified Sleep Physician & theREALsleep.)

Signature of Referring Physician: _____ Date:_____