**Local Home Health Provider**
Prism Health Care Services, Inc
1337 Basswood Road
Schaumburg, IL 60173
Phone: 847-310-4730
Fax: 872-469-1673

# EzSlep
## HSAT your Way
## 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-nights unattended, Portable Recorder with minimum four (4) channels, for example: Records airflow, respiratory effort, $O_2$ saturation and heart rate. Performed on room air unless specified below.**

☐ **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**

Prescriber Signature & Certification: (Stamped dates / signatures not valid. Must be signed by Prescriber / PA / NP)

## 8 Sign Here: X _____ Date: _____

**Please fax completed order form & insurance card back to (800) 209-9193**

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