BLACKSTONE MEDICAL SERVICES
CONTACTLESS DIAGNOSTIC TESTING

SAVE TIME
ORDER ONLINE

PHYSICIANS ORDER FOR HOME SLEEP TEST

Patient Name _____ SSN _____

DOB _____ Best / Daytime Phone # _____ Alternate Phone _____

Street Address _____ Email _____

City _____ State _____ Zip _____ ☐ Male ☐ Female

Primary Insurance _____ ID Number _____

Secondary Insurance _____ ID Number _____

Height _____ Weight _____ BMI _____ Neck Circumference _____

Patient on Supplemental Oxygen: ☐ Yes ☐ No Patient Currently on PAP therapy: ☐ Yes ☐ No

STUDY REQUESTED (CPT-4)

☐ 95806 / G0399 / 95800 Home Sleep Test

CHIEF COMPLAINT:

☐ Snoring ☐ Observed Apnea

☐ Choking or Gasping during sleep ☐ Fatigue

☐ Excessive Daytime Sleepiness ☐ Hypertension

☐ Other _____

DIAGNOSIS CODE (ICD-10)

☐ G47.33 Obstructive Sleep Apnea

☐ G47.30 Sleep Apnea, Unspecified

☐ G47.39 Other Sleep Apnea

☐ G47.10 Hypersomnia, Unspecified

EPWORTH SLEEPINESS SCALE:

For Insurance Purposes - assessment below must be completed prior to ordering a HST

0 - **NO** Chance of Dozing **1** - **SLIGHT** Chance of Dozing **2** - **MODERATE** Chance of Dozing **3** - **HIGH** Chance of Dozing

	0	1	2	3
Sitting and Reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place	☐	☐	☐	☐
Passenger in car under an hour	☐	☐	☐	☐

	0	1	2	3
Lying down to rest in the afternoon	☐	☐	☐	☐
Sitting & Talking w/ someone	☐	☐	☐	☐
Sitting quietly after lunch w/o alcohol	☐	☐	☐	☐
In a car stopped in traffic	☐	☐	☐	☐

Physician Name _____ Physician NPI # _____ Phone _____

Address _____ Office Contact / Title _____

Physician Signature _____

Date _____

Fax Results _____

The information contained in this transmittal is confidential. If you have received it in error please contact our office and discard. Thank you!

PREFERRED DME COMPANY

Company Name _____

Fax Number _____