FIRST STEP Home Sleep Testing INC.

HOME SLEEP TESTING INTAKE FORM
Please send by FAX to: 217-253-2221
217-253-3333
(1-844) 807-5333

TO PREVENT DELAY IN TESTING, PLEASE BE SURE TO COMPLETE ALL SECTIONS AND CONFIRM PATIENT'S CONTACT INFORMATION

PATIENT INFORMATION

LAST NAME:	FIRST NAME:		DATE OF BIRTH (mm/dd/yyyy):	GENDER: MALE: ☐ FEMALE: ☐
REFERRED BY:	HEIGHT:	WEIGHT:	EMAIL:	
ADDRESS:	CITY:		STATE:	ZIP CODE:
PRIMARY PHONE #:	SECONDARY PHONE #:		EMERGENCY CONTACT:	

PERSCRIBER INFORMATION

ORDERING PROVIDER NAME:	PHONE #:	FAX #:
OFFICE CONTACT NAME:	NPI #:	EMAIL:

PAYMENT AND/OR INSURANCE INFORMATION

MUST CHECK ONE:
*WE CAN OBTAIN CREDIT CARD INFO ON DELIVERY
PATIENT REQUESTS PRIVATE PAYMENT: ☐
PATIENT REQUESTS INSURANCE BILLED: ☐ *PLEASE FAX COPY INSURANCE CARD

CREDIT CARD #:	EXP. DATE: /	SECURITY CODE:
CARD HOLDER NAME:		

PRIMARY PLAN:	MEMBER ID:	POLICY HOLDER NAME:	POLICY HOLDER D.O.B. (mm/dd/yyyy):
SECONDARY PLAN:	MEMBER ID:	POLICY HOLDER NAME:	POLICY HOLDER D.O.B. (mm/dd/yyyy):

MEDICAL HISTORY/SYMPTOMS/DIAGNOSIS

ICD-10 Code G47.33 will be used for this Obstructive Sleep Apnea (OSA) test unless otherwise specified.

Certain Payers require as many as 4 symptoms but at least 2. Please check all that apply.
Certain Payers require medical documentation/progress notes regarding testing for Sleep Apnea. Please attach these.

	Morning Headaches		Gasping/Choking while Sleeping		Previous Diagnosis of OSA
	Daytime Sleepiness/Napping		Irritability/Moodiness		Assessment of Efficacy of Surgery
	Drowsy Driving		Hypertension		Assessment of Oral Appliance
	Fatigue		Witnessed Apneic Events		Abnormal Nocturnal Oximetry
	Habitual Snoring		Witnessed Nocturnal Motor Activity		High Fasting Blood Sugar Levels
	History of Coronary Artery Disease		Atrial Fibrillation		Polycythemia
	Forgetfulness		Other (Specify):		

Epworth Sleepiness Scale Score (Range 0 – 24; ≥ 10 = HIGH RISK):		STOP BANG score:
Mallampati Scale:	BMI:	Neck circumference:

TEST TYPE – Home Sleep Test Only will be administered if nothing is checked below.

	Home Sleep Test Only		Home Sleep Test including Titration Test; If patient is positive for Obstructive Sleep Apnea
	Titration Test Only	If Sleep Test was **not done** by ***First Step***, supply date of last Sleep Test: / /	AHI:

DESIGNED THERAPY/ DURABLE MEDICAL EQUIPMENT (DME) PROVIDER AND RELEASE OF TEST RESULTS
By entering contact information below, provider directs that any test results (whether positive or negative) additionally be sent to the therapy/DME provider for purposes of treatment of the patient.

Therapy/DME Provider Name:	PHONE #:	FAX #:

ATTENTION: Patients who cannot be removed from CPAP or Oxygen to administer the FirSTep HST overnight should have attended, in-lab sleep test.

By signing below, I attest that: upon my examination of the patient, which included Neurological, Cardiovascular, Chest/Lung, HEENT, and Vital Signs, there is a high probability of OSA. A Home Sleep Test is medically necessary and no co-morbid conditions are present that prevent the patient from home testing.

Provider's *Written* Signature

Date