Epoch sleep well
Sleep Centers & Neuro-Diagnostics
www.epochsc.com

ACCREDITED MEMBER CENTER

SLEEP STUDY & TREATMENT ORDER FORM

Rhode Island
Phone: 401-541-9188
Referral Fax: 401-541-9199

Massachusetts
Phone: 508-646-4303
Referral Fax: 508-646-4304

Locations Across Rhode Island, Massachusetts, & Connecticut

PATIENT INFORMATION

Name: _____ DOB: _____ M/F: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Primary Insurance: _____ Insurance #: _____

Suspected Disorders/Diagnosis
(Please check all that apply)

- ☐ Obstructive Sleep Apnea (OSA)
- ☐ Insomnia
- ☐ Nocturnal Seizures/parasomnia
- ☐ Restless leg syndrome (RLS) or Periodic Limb movements of sleep (PLMS)
- ☐ Narcolepsy

Primary Symptoms
(Please check all that apply)

- ☐ Snoring/gasping /choking
- ☐ Witnessed Apneas
- ☐ Obese /Large neck
- ☐ Daytime Fatigue
- ☐ Difficulty Falling Asleep
- ☐ Frequent Awakening/Fragmented Sleep
- ☐ Frequent leg movements during sleep
- ☐ S/P Airway Surgery
- ☐ Hypertension
- ☐ Depression/Mood Disorders
- ☐ Other _____

PLEASE PROVIDE MOST RECENT CLINICAL NOTES REGARDING SUSPECTED SLEEP DISORDER.

DIAGNOSTIC TESTING & TREATMENT

DIAGNOSTIC TEST TYPES

☐ **Home Sleep Apnea Test**
☐ **If Test is Positive for G47.33 Obstructive Sleep Apnea, Please Provide Therapy Type: APAP (4-20CM H20) Humidification: Heated • Length of Need: 99 Months**

- ☐ **Standard In Lab Sleep Study**
- ☐ **Split Night in Lab Study (Sleep Study and Pap Titration)**
- ☐ **CPAP/Bilevel Titration**
- ☐ **MSLT (Daytime Sleep Study in Lab preceded by full night Sleep Study)**

Order includes all supplies and accessories necessary for the compliant use of the prescribed equipment

E0562 humidifier, heated A7031 Full Face Cushion A7036 Chinstrap A7044 Oral mask A7027 Oral/nasal mask A7032 Nasal cushion A7037 Tubing A7046 Humidifier chamber A7028 Oral/Nasal Cushion A7033 Nasal Pillow A4604 Tubing-heated A7029 Oral/Nasal pillows A7034 Nasal mask A7038 Filter-disp A7030 Full Face mask A7035 Headgear A7039 Filter-reusable

☐ **SLEEP MEDICINE SPECIALIST FOR CONSULTATION**

EPWORTH SLEEPINESS SCALE - MUST BE COMPLETED FOR PRECERTIFICATION Height _____ Weight _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation Chance of Dozing	Scale	Situation Chance of Dozing	Scale
Sitting and reading	☐	Laying down to rest in the afternoon	☐
Watching TV	☐	Sitting and talking to someone	☐
Sitting inactive in a public place	☐	Sitting quietly after lunch (without alcohol)	☐
Being a passenger in a car for an hour without a break	☐	Sitting for a few minutes in traffic while driving	☐

Total score equals your EES ☐

PROVIDER INFORMATION

Referring Physician /NP/PA Name: _____

_____
Physician /NP/PA Signature **Date**

Phone: _____ Fax: _____

Primary Care Physician Name: _____ NPI: _____

FOR SLEEP CENTER ONLY
Check if physical exam is listed in referring M.D.'s notes ☐
History reviewed by _____ M.D.
Date _____/_____/_____

Revised 7/17