Watch-PAT®
Home Sleep Study
Prescription / Order

Certificate of Medical Necessity

Patient (Last, First, MI)_____ **Today's Date** _____

Insurance Carrier/ ID#_____ **Date of Birth (mm/dd/yyyy)** _____

Patient Address_____ **Home Phone**_____( )*

_____ **Work Phone**_____( )*

_____ **Cell Phone**_____( )*

Email_____ (*indicated preferred number to contact)

Height_____**Weight**_____**(or BMI)**_____ **Epworth Score**_____ **Male** ▢ **Female** ▢

▢ **HOME SLEEP STUDY 1**	▢ **HOME SLEEP STUDY 2**	▢ **HOME SLEEP STUDY 3**	▢ **HOME SLEEP STUDY 4**
w/ Certified Sleep Physician Interpretation **"HIGH PROBABILITY OF OSA"** (ESS≥10, BMI≥30 & symptoms (√ below))	w/ Certified Sleep Physician Interpretation **FOLLOW UP** Indication(Circle): CPAP* OAT* Surgery Weight Loss *Perform Study W▢ W/O▢ Therapy	w/ Certified Sleep Physician Interpretation **OSA Suspected** Patient Pay (Non-conforming Sleep Parameters)	Comprehensive Sleep Study Report **w/o** Interpretation **OSA Screening** Patient Pay Quantification by Qualified physician for snoring/treatment

Does patient have a permanent pacemaker? ▢ **Yes** ▢ **No**

Is the patient on Oxygen? ▢ **Yes**** ▢ **No**

****If Yes - is on room air testing approved?** ▢ **Yes** ▢ **No**

Sleep History / Conditions / Symptoms (check all applicable - at least one)

√		√		√		√	
▢	**Loud, Disruptive Snoring**	▢	**Ischemic Heart Disease**	▢	**Impaired Cognition**	▢	**Diabetes**
▢	**Witnessed Apnea > 10 sec. by** _____	▢	**Chronic Fatigue**	▢	**Morning Headaches**	▢	**Elongated Soft Palate**
▢	**Gasping or Snorting (During Sleep or Upon Waking Up)**	▢	**Hypertension**	▢	**Insomnia**	▢	**Nasal Obstruction**
▢	**Excessive Daytime Sleepiness**	▢	**History of Stroke**	▢	**Obesity**	▢	**Swollen Turbinates**
▢	**Please list any medications taken:**						

Primary Diagnostic ICD-10 Code (check only one)

▢	**G47.33 Obstructive Sleep Apnea (Adult & Pediatric)**	▢	**G47.30 Unspecified Sleep Apnea**	▢	**R06 General Snoring**

PATIENT'S INSURANCE INFORMATION: ***Attach copy of front and back of insurance card****

PATIENT'S SIGNATURE TO AUTHORIZE INSURANCE BILLING:

☑ By signing below, I acknowledge that I have received and read 1st Line Medical, Inc.'s Policy Statement including Instructions For Use, return of the diagnostic system, potential financial obligations and give permission to 1st Line Medical, Inc. to conduct the diagnostic service and submit a claim to my health insurer if applicable.

_____ _____

Patient Signature **Date**

_____ _____ _____

Physician Signature **Date** **Physician Name (printed)**

Submit via Fax #: 800-918-7860

Phone Number: 866-720-8080

Patient Name: _____ Date: _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. 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
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

To check your sleepiness score, total the points. _____

EPWORTH SLEEPINESS SCALE KEY

1 - 6	Your score is low
7 - 8	Your score is average
9 and up	Seek the advice of a sleep specialist without delay