PO Box 1207
Dover, DE 19903

Independent Sleep Diagnostics LLC
Home Sleep Testing Experts

Phone: 855-777-3211
FAX: 302-674-4168

Home Sleep Test Prescription Form

Please FAX completed form to: 302-674-4168

Patient Demographics:

Name:_____ Date of Birth:_____

Phone:_____ Alternate Phone:_____

Referring Physician Demographics:

Physician Name:_____ NPI:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____ Email:_____

Procedure Order:

_____ HST (Home Sleep Test)

Clinical Symptoms:

Please check ALL symptoms that describe the patient's sleep complaint(s):

_____ ***Excessive Daytime Sleepiness** _____ ***Insomnia** _____ ***Impaired Cognition**

_____ ***Mood Disorders** _____ Snoring _____ Witnessed Apnea

_____ Morning Headache _____ Restless Sleep _____ Restless Legs

_____ Nocturnal Choking _____ Loud Snoring _____ Hyper Somnolence

Health History:

_____ ***Hypertension** _____ ***History of Stroke** _____ ***Ischemic Heart Disease**

_____ BMI > 35 (Morbid Obesity) _____ Pulmonary Disease _____ Heart Failure

_____ Other Cardio Vascular Disease _____ Polycythemia _____ Diabetes

Other/Description: _____

***One of these symptoms needs to be marked for a patient who has an AHI between 5 and 14 to qualify for home CPAP.**

I have referred the above patient for a home sleep study for the reasons indicated on this form.

_____ _____
Ordering Physician Signature Date