REM DIAGNOSTICS
SPECIALISTS IN SLEEP

Home Sleep Study Order Form
(Fax to 805-785-0127)

Date	Name	Cell Phone	Home Phone
Address	City	State	Zip
DOB	SS#	Emergency Contact	Emergency Phone

Referring Physician	Phone	Fax	NPI
Insurance 1	ID	Group #	Phone
Insurance 2	ID	Group #	Phone

Send copies of both primary and secondary insurance cards.

Clinical Evaluation

Height	**Weight**	**BMI**	**Neck Size**	**Epworth Score**

Sleep History (Check Primary Signs and Symptoms) REQUIRED

☐ Oral Appliance Assessment ☐ Excessive Daytime Sleepiness	☐ Observed Apneas ☐ Gasping/Choking	☐ Hypersomnia ☐ Daytime Somnolence ☐ Other_____

Sleep History (Check Secondary Signs and Symptoms)

☐ Depression ☐ Dry Mouth in AM	☐ Morning headaches ☐ Sleep Disordered Breathing ☐ Insomnia	☐ Loud Snoring ☐ Non-Restorative Sleep ☐ Other_____

Cardiopulmonary/Upper Airway Exam (Check all that apply):

☐ Nasal Obstruction ☐ Teeth Worn ☐ Maxillomandibular Abnormalities	☐ Over/Under Bite ☐ Enlarged Tongue ☐ Crowded Hypopharynx	☐ Crowded Oropharynx ☐ Enlarged Tonsils	☐ Hypertension ☐ Retrognathia/Micrognathia ☐ Obesity

Diagnostic Codes (Check all that apply):

☐ G47.10 Hypersomnia	☐ G47.30 Sleep Apnea	☐ G47.33 Obstructive Sleep Apnea (adult or pediatric)	☐ Other

CPT Codes (Please check)

☐ 95806 Commercial Plans	☐ G0399 Medicare

Prescriber Signature & Certificate - I, the undersigned, certify that I am the patient's treating physician and the information contained on this form is based on a face-to-face office visit. I am prescribing a one-night HST as medically necessary.

Signature (Please no stamps)_____**Date**_____

REM Diagnostics, Inc.
1329 Broad St, Ste C
San Luis Obispo, CA 93401

Phone (805) 785-0126
Fax (805) 785-0127
www.remdiagnosticsinc.com