Epoch sleep well | COASTAL Sleep Diagnostics | Epoch An Epoch Sleep Well Company

www.epochsc.com

ACCREDITED MEMBER CENTER

HOME SLEEP STUDY & TREATMENT ORDER FORM

Massachusetts

Phone: (781) 740-9155 | Fax: (781) 740-9156
Email: csteam@epochsc.com

Rhode Island

Phone: (401) 541-9188 | Fax: (401) 541-9199
Email: csteam@epochsc.com

PATIENT INFORMATION

Name: _____ DOB: _____ Gender: _____

Home Phone: _____ Cell: _____ Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Primary Insurance: _____ Insurance #: _____

SUSPECTED DISORDER/DIAGNOSIS

☐ Obstructive Sleep Apnea (OSA)

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
- ☐ Hypertension
- ☐ Depression/Mood Disorders
- ☐ Other _____

DIAGNOSTIC TESTING & TREATMENT OPTIONS

☐ Home Sleep Apnea Test Only

☐ Sleep Medicine Specialist For Consultation Only (Now Providing Sleep Medicine Tele-Consultations)

☐ Home Sleep Apnea Test & Sleep Medicine Specialist For Consultation

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

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

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 _____/_____/_____

Please Provide Most Recent Clinical Notes Regarding Suspected Sleep Disorder