

Prescription and Order Form



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Empowering people to save their lives

<b>PRESCRIBER</b>	Name: _____ NPI: _____ Ph#: _____ Address/City/ST/Zip: _____ Fax: _____ Office Contact: _____ Ph#: _____ Email: _____ Referring Provider: _____ Ph#: _____ Email: _____ ~~~~~ DME preference: _____ Ph#: _____ *If DME preference is left Blank MySleep will assign a DME for the patients plan of care* Fax: _____ Address/City/ST/Zip: _____		
<b>PATIENT</b>	Name: _____ Cell: _____ Address/City/ST/Zip: _____ Home: _____ DOB (mm/dd/yyyy): _____ Gender: <input type="checkbox"/> M / <input type="checkbox"/> F Email: _____ Language preferred: _____ Emergency Contact & PHONE: _____		
<b>PAYMENT</b>	<input type="checkbox"/> Bill Patient's Insurance <input type="checkbox"/> Patient Self-Pay of \$299 Primary Plan: _____ ID: _____ Grp: _____ Ph#: _____ Secondary Plan: _____ ID: _____ Grp: _____ Ph#: _____ Policy Holder's name (if not Self): _____ DOB (mm/dd/yyyy): _____		
<b>CARDIAC MONITOR</b>	<input type="checkbox"/> 72-hr Extended Wireless Holter + MCT * <b>DIAGNOSIS</b> (check all that apply): <input type="checkbox"/> Mobile Cardiac Telemetry /MCT <input type="checkbox"/> Tachycardia / R00.0 <input type="checkbox"/> Palpitations / R00.2 <input type="checkbox"/> Paroxysmal AFib / I48.0 <input type="checkbox"/> Bradycardia / R00.1 <input type="checkbox"/> Dizzy or Giddy / R42.0 <input type="checkbox"/> Abnormal EKG / R94.31 <input type="checkbox"/> Syncope / R55.0      other: _____ <b>TEST DURATION</b> <input type="checkbox"/> 3 Days <input type="checkbox"/> 7 Days (default, if not specified) <input type="checkbox"/> I plan to INTERPRET TEST RESULTS <input type="checkbox"/> 14 Days      other: _____ (if BLANK, defaults to MySleep cardiologists panel)		
<b>HOME SLEEP TEST</b>	<input type="checkbox"/> Sleep Apnea Study <b>DIAGNOSIS</b> (check all that apply): Room air up to 2 nights unattended, portable recorder with minimum 4 channels (airflow, resp effort, POX & heart rate) <input type="checkbox"/> OSA / G47.33 <input type="checkbox"/> Hypersomnia / G47.10 <input type="checkbox"/> Sleep Apnea, other / G47.39 EPWORTH SCORE: _____ <input type="checkbox"/> AFib / I48.91 <input type="checkbox"/> CSA / G47.31 <input type="checkbox"/> Hypertension / I10.0 <input type="checkbox"/> Sleep Apnea, unspec / G47.30 <input type="checkbox"/> COPD / J44.9 <input type="checkbox"/> CHF / I50.21 <input type="checkbox"/> Resp. Failure / J96.90      other: _____ Patient on Oral Appliance <input type="checkbox"/> <b>SYMPTOMS</b> (check all that apply): <input type="checkbox"/> Apneas Observed <input type="checkbox"/> Depression / irritability <input type="checkbox"/> Morning Headaches <input type="checkbox"/> Daytime Fatigue / driving drowsy <input type="checkbox"/> Dry Mouth / sore throat <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Awake Gasping / choking <input type="checkbox"/> Snores Regularly		
<b>SIGN</b>	Prescriber: _____ Date: _____ (signature)		

Please fax completed order form, demographics & insurance card 888-453-4626

NOTE: Signature & date stamps are not valid. This order must be signed by the designated prescriber (above), MD, DO, NP or PA to execute the directive.

\* Patient will receive a 72-hour Extended Wireless Holter followed by an MCT test if the Extended Wireless Holter is found to be unrevealing, per the policy posted on www.MySleep.live. If a Mobile Cardiac Telemetry (MCT) or a 72-hour Extended Wireless Holter + MCT test is ordered and either the patient's insurance does not cover the MCT test or the patient does not qualify for the MCT test, this constitutes my written authorization for a Cardiac Event Monitor test of equivalent duration as an alternative to the original order. I affirm that I have reviewed and agree to the Physician Notification criteria posted on www.MySleep.live. CONFIDENTIAL DETAIL IS CONTAINED IN THIS TRANSMISSION. IF YOU RECEIVED THIS FAX IN ERROR, PLEASE CONTACT OUR OFFICE AT 888-324-7781 AND DESTROY THE MATERIAL. THANK YOU.

