Prescription and Order Form

888-324-7781 | 888-453-4629 | www.MySleep.Live

PRESCRIBER

Name: ______________ NPI: __________ Ph#:: ______________

Address/City/ST/Zip: ______________ Fax: ______________

Office Contact: ______________ Ph#: __________ Email: ______________

Referring Provider: ______________ Ph#: __________ Email: ______________

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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: ______________

PATIENT

Name: ______________ Cell: ______________

Address/City/ST/Zip: ______________ Home: __________ DOB (mm/dd/yyyy):__________

Gender: ☐ M / ☐ F Email: ______________

Language preferred: __________ Emergency Contact & PHONE: ______________

PAYMENT

☐ Bill Patient's Insurance ☐ Patient Self-Pay of $250

Primary Plan: __________ ID: __________ Grp: __________ Ph#: __________

Secondary Plan: __________ ID: __________ Grp: __________ Ph#: __________

Policy Holder's name (if not Self): ______________ DOB (mm/dd/yyyy): ______________

CARDIAC MONITOR

☐ 72-hr Extended Wireless Holter + MCT *

☐ Mobile Cardiac Telemetry /MCT

DIAGNOSIS (check all that apply):

☐ Palpitations / R00.2:
☐ Paroxysmal AFib / I48.0
☐ Tachycardia / R00.0
☐ Dizzy or Giddy / R42.0
☐ Abnormal EKG / R94.31
☐ Bradycardia / R00.1
☐ Syncope / R55.0
other: __________

TEST DURATION

☐ 3 Days
☐ 7 Days (default, if not specified)
☐ I plan to INTERPRET TEST RESULTS (If BLANK, defaults to MySleep cardiologists panel)
☐ 14 Days
other: __________

HOME SLEEP TEST

☐ Sleep Apnea Study
Room air up to 2 nights unattended, portable recorder with minimum 4 channels (airflow, resp effort, POX & heart rate)

EPWORTH SCORE: __________

Patient on Oral Appliance ☐

Patient on Oxygen ☐

Patient on PAP Device ☐

DIAGNOSIS (check all that apply)

☐ OSA / G47.33
☐ Hypersomnia / G47.10
☐ Sleep Apnea, other / G47.39
☐ AFib / I48.91
☐ CSA / G47.31
☐ Hypertension / I10.0
☐ Sleep Apnea, unspec / G47.30
☐ COPD / J44.9
☐ CHF / I50.21
☐ Resp. Failure / J96.90
other: __________

SYMPTOMS (check all that apply):

☐ Depression / irritability
☐ Morning Headaches
☐ Apneas Observed
☐ Dry Mouth / sore throat
☐ Poor Concentration
☐ Daytime Fatigue / driving drowsy
☐ Awake Gasping / choking
☐ Snores Regularly

SIGN

Prescriber: ______________________ Date: __________
(signature)

<u>Please fax completed order form, demographics & insurance card 888-453-4629</u>

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.

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