AAA MEDICAL SOLUTIONS
An Independent Diagnostic Testing Facility
412 S. King Ave., Ste 100 Middleton, ID 83644
www.idtf.com

Fax completed form, chart notes and insurance card(s) to: (208) 639-6608
For questions about this form or the test, call: (866) 710-5779 Option 4

HOME SLEEP TEST ORDER

PATIENT INFORMATION

Patient Name (Last, First):				
Date of Birth (mm/dd/yyyy):	Gender:	Neck Circ.(in)	Height:	Weight:
Address (No PO Boxes):			Apt. #	
City:		State:	Zip:	
Preferred Phone:	Alternate Phone:	Language (if other than English)		

POLICY HOLDER INSURANCE INFORMATION

Please also include a photocopy of front and back of insurance card

Primary Insurance:	Subscriber ID:	Name:	Birth Date:
Secondary Insurance:	Subscriber ID:	Name:	Birth Date:

STOP-BANG QUESTIONNAIRE

	Yes	No
1. Do you snore loudly (louder than talking or to be heard through closed doors)?	☐	☐
2. Do you often feel tired, fatigued, or sleepy during daytime?	☐	☐
3. Has anyone observed you stop breathing during sleep?	☐	☐
4. Do you have or are you being treated for high blood pressure?	☐	☐
5. BMI more than 35kg/m2?	☐	☐
6. Age over 50 years old?	☐	☐
7. Neck circumference greater than 40 cm?	☐	☐
8. Gender male?	☐	☐

ASSOCIATED SYMPTOMS (MEDICAL NECESSITY)

☐ Loud Snoring	☐ Morning Dry Mouth	☐ Assess Efficacy of Oral Appliance	☐ Hypertension
☐ Observed Apnea	☐ Awaken Choking or Gasping	☐ Assess Efficacy of Other Treatment	☐ Depression
☐ Insomnia	☐ Excessive Daytime Sleepiness	☐ Other:___________________	

PROCEDURE

☐ G0398/95800 Unattended, 2 night, type 2 Portable Recorder (min. 7 channel)

☐ **Test on current O2 prescription (patient to provide own O2)? ☐YES ☐NO**

DIAGNOSIS

☐ 327.23 - Obstructive Sleep Apnea ☐ 780.51 - Insomnia w/OSA ☐ 780.53 - Hypersomnia w/OSA ☐ 780.57 - Unspecified Sleep Apnea

PREFERRED DME

DME Name:	Phone:	Fax:

PRESCRIBING PHYSICIAN INFORMATION

Ordering Physician Name:		Phone:	Fax:
NPI:	Office Contact Name:		Ext.:

PHYSICIAN ATTESTATION AND SIGNATURE: * Required

I, the undersigned certify that I have evaluated this patient face-to-face for signs & symptoms of Obstructive Sleep Apnea and such has been documented in the patients permanent medical records prior to this order for a home sleep test. Chart notes from his/her visit are included with this order. I certify that this order is not a screening for an asymptomatic patient. If DME is identified above, please direct any test results for purposes of treatment of the patient.

PHYSICIAN SIGNATURE X:____ Date:_____/______/_________

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AAA MEDICAL SOLUTIONS
Getting it done right...right now.
An Independent Diagnostic Testing Facility

Phone: 1-866-710-5779 Fax: (208) 577-2893
412 S. King Ave., Ste 100 Middleton, ID 83644

PATIENT INSTRUCTIONS / CHECKLIST FOR THE HOME SLEEP TEST

Dear valued patient,

Enclosed with this letter are a number of things you will need to complete and return to us in order to achieve a successful home sleep test. We have done everything possible to ensure the process is simple and straight forward but we welcome your input if you have some suggestions that would improve it.

Please check each item off below as it is completed. Your results cannot be released to your physician until we have it completed and returned to us.. Should you have any questions about this testing process, please contact AAA Medical Solutions at **1-866-710-5779** or visit **www.idtf.com** and follow the Home Sleep Test Patient Information link.

STEP 1 ☐

COMPLETE THE TEST: Along with this letter, there will be an instruction sheet for the device. This will instruct you how to set yourself up on the device and operate it properly. You should keep the test kit and repeat the same procedures for 2 nights. If you need assistance with setting up the device, call the 24 hr. technical support line on the instruction sheet.

STEP 2 ☐

COMPLETE THE QUESTIONNAIRE: Along with this letter is a sheet titled ***"HOME SLEEP TEST - POST SLEEP QUESTIONNAIRE"***. This form is to aid our physicians in the interpretation of the data collected on the device.

STEP 3 ☐

COMPLETE THE INSURANCE PAPERWORK: Along with this letter is a sheet titled ***"PATIENT INSURANCE INFORMATION AND MEDICAL RECORDS RELEASE"***. Although you may have already provided this information to us, please fill it out entirely again as a double measure of accuracy. We cannot process the results until we have verified payment. We also cannot release the results to anyone without your signature on the bottom of the form.

STEP 4 ☐

DISCONNECT AND THROW AWAY THE NASAL CANNULA: The nasal cannula is the clear tubular sensor that you wore during the test. For sanitary reasons, it must be thrown away.

STEP 5 ☐

RETURN THE PAPERWORK AND THE DEVICE: A self-addressed, pre-paid box has been provided to make this easy. Simply put everything back in the box. Call us at 1-866-710-5779 ext. 210 and we will send someone to pick it up.

STEP 6 ☐

DISCUSS THE RESULTS WITH YOUR PHYSICIAN: Depending on your proximity to our office, please allow 4-6 days for the device to be returned to us and to be processed. Once we've processed the results, they will be faxed to your physician. Your physician should then schedule a follow-up visit with you to discuss whether or not treatment is necessary and what those treatment options are. Please call us at 1-866-710-5779 ext. 210 if you would like a copy of your report.

We thank you for your business and sincerely hope that your quality of sleep is greatly improved in the near future.

Sincerely,

The Staff and Management of AAA Medical Solutions, Inc.

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