Obstructive Sleep Apnea Patient Packet

Patient:

Last Name: _____ First: _____

Birth Date: _____ ☐ Male ☐ Female

Treating Physician: NPI -	Local Treatment Supplier: 1037027
	OLSON MEDICAL LLC 2515 MAIN ST, PARSONS, KS 67357-2727 Ph: (620)421-2727 Fax: (620)421-2744

Attached:

Patient Screening Form - Includes validated STOP Quiz and Epworth Sleepiness Scale to assess primary symptoms and risk for Obstructive Sleep Apnea. May be self-completed by patient.

Clinical Evaluation Form - Intended to aid in-person examination following a positive symptom screening.

Home Sleep Test Order Form - Complete, Sign, and Fax to order the IDS independent diagnostic testing facility to perform a home diagnostic test confirm suspicion of Obstructive Sleep Apnea

Home Sleep Test Patient Guide - Educational guide to distribute to patient so they will further understand reasoning for testing and what to expect. This form is key to avoiding patient refusal, scheduling difficulties, etc.

Other Attachments :

ADDITIONAL NOTES :

Document Rev 9/19/2012

Home Sleep Testing service and IDS forms provided by:

Instant Diagnostic Systems, Inc - IDS
Independent DIagnostic Testing Facility, NPI 1922017516
1740 4th Ave SE, Suite A, Decatur, AL 35601
Phone: 800-355-0691

IDS
Instant Diagnostic Systems

Patient Self-Screening Form
S.T.O.P. / Epworth Sleepiness Scale

Treating Physician: NPI -

Last Name: _____ First: _____

Birth Date: _____ ☐ Male ☐ Female Height: _____ Weight: _____ Neck Circumference (or Collar Size) _____

The S.T.O.P. Quiz

		Yes	No
1. *Snoring*	**Do you snore loudly?**	☐	☐
2. *Tired*	**Do you often feel tired, fatigued, or sleepy during the daytime?**	☐	☐
3. *Observed*	**Has anyone observed you stop breathing (choking, gasping) during your sleep?**	☐	☐
4. *Pressure*	**Do you have, or are you being treated for high blood pressure?**	☐	☐

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to think about how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = *Never* doze
1 = *Slight* chance of dozing
2 = *Moderate* Chance of dozing
3 = *High* Chance of dozing

Chance of Dozing Score 0-3:	**Situation:**
____	Sitting and reading
____	Watching TV
____	Sitting, inactive in a public place (i.e. a theater or in a meeting)
____	As a passenger in a car for an hour without a break
____	Lying down to rest in the afternoon when circumstances permit
____	Sitting and talking to someone
____	Sitting quietly after a lunch without alcohol
____	In a car while stopping for a few minutes in traffic
_____	**TOTAL (This is your Epworth Score!)**

Summary:

Discuss results with your physician as soon as possible about your high risk for sleep apnea if:

☐ You answered 'YES' to TWO or more questions in the Stop Quiz, **or** ONE YES and you fit any of the following criteria: Male - Over 50 - Overweight - Large Neck Circumference (collar size).

OR...

☐ Your "Epworth Sleepiness Scale" Score total is 9 or higher

Disclaimer: The validated questionnaires on this form are intended to help assess patients that may be at risk for OSA. It is not intended to replace clinical judgement of the treating physician in the diagnosis of OSA.
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OLSON MEDICAL LLC
2515 MAIN ST,
PARSONS, KS 67357-2727
Ph: (620)421-2727 Fax: (620)421-2744

Rev 9/19/2012

Obstructive Sleep Apnea Initial Clinical Evaluation Form

Instant Diagnostic Systems

Treating Physician: NPI -

Patient Profile:

Last Name: _____ First: _____

Birth Date: _____ Age: _____ ☐ Male ☐ Female

Height (in): _____ Weight (lbs): _____ BMI: _____ Neck Circumference (in): _____

1. Patient Symptom Screening:

☐ I. Symptom Score (0 - 4). Only Highest of 2 scores at right

Review results from IDS Screening Form (or use STOP quiz at right). Enter only the HIGHEST of the two blanks in the box at left

'S.T.O.P. Quiz' Screening Score (Enter count of 'Yes' responses): _____

Epworth Sleepiness Score > 8 ? (If yes, Enter 2 here): _____

The STOP Quiz

If not completed by patient on Self-Screening form.

- ☐ **Snore Loudly**
- ☐ **Tired, fatigued, or sleepy frequently during the daytime**
- ☐ **Observed breathing pauses, choking or gasping during sleep**
- ☐ **High Blood Pressure**

2. Physician Evaluation: (requires Symptom score of 1 or more from Section 1)

☐ II. Enter Count of Checked Boxes Score 0 - 5

Examine patient and check all that are applicable. Enter total number of checked boxes in left column.

- ☐ **Obese (BMI > 30)**
- ☐ **Large Neck Circumference (Typically > 15.75")**
- ☐ **Upper-airway structural abnormalities (One or more of the following)**
  - ○ **Small Mandible or 'Overbite'**
  - ○ **Enlarged Tonsils**
  - ○ **Large Tongue**
  - ○ **Large Uvula**
  - ○ **Small Posterior Oral Airway**
- ☐ **Male**
- ☐ **Age - Over 40 years**

BMI > 30 for the height/weight below

Height	Weight	Height	Weight
54	125	68	198
55	130	69	203
56	134	70	210
57	139	71	215
58	144	72	221
59	149	73	228
60	154	74	234
61	159	75	240
62	164	76	247
63	170	77	253
64	175	78	260
65	181	79	267
66	187	80	274
67	192	81	281

3. OSA RISK:

Either of the following suggests a high risk for OSA and strong consideration should be given for sleep testing:

Total Score
Sum of Section 1 + 2 ☐

Section 1 only: Score of 2 or more = Risk

Combined section 1 + 2: Total of 2 or more = Risk

4. Diagnostic Decision:

Home Sleep Test (HST):

☐ Intended for symptomatic patients (a Section 1 score greater than 0) with high pre-test risk for OSA (total score = 2 or more). 'Not intended for asymptomatic patients or to diagnose disorders other than OSA.

Sleep Specialist / In-Lab PSG:

☐ Should be considered for patients with suspected secondary sleep disorders & cases with complex medical history that may cause home testing or treatment to be more difficult.

Disclaimer: This document is a suggested set of guidelines to aid initial evaluation for obstructive sleep apnea and should never be used without clinical correlation and judgment for each individual case. Practice parameters for diagnosis and treatment of OSA are available from the AASM & available at aasmnet.org.

OLSON MEDICAL LLC
2515 MAIN ST,
PARSONS, KS 67357-2727
Ph: (620)421-2727 Fax: (620)421-2744

Home Sleep Test Order Form

IDTF: Instant Diagnostic Systems, Inc.
- 1740 4th Ave SE, STE A, Decatur, AL 35601 -
- 25060 Ave Stanford #270, Valencia, CA 91355 - Ph: 800-355-0691 -

1 Patient Information: *Indicates required fields.

*Last Name:_____ *First: _____

*Phone: (_____) _____ Alt. Phone: (_____) _____

*Date of Birth: _____ * ☐Male ☐Female *Height:_____in *Wt:_____lbs

Address: _____

City: _____ State:_____ Zip: _____

1300274

2 Insurance:

Please attach a copy of insurance card or face sheet.
-- MOST MEDICAID NOT ACCEPTED AT THIS TIME --

Local Treatment Supplier: 1037027

OLSON MEDICAL LLC
2515 MAIN ST,
PARSONS, KS 67357-2727
Ph: (620)421-2727 Fax: (620)421-2744

3 Test Procedure:

Home Sleep Test: Type III Study, On Room Air to evaluate for Obstructive Sleep Apnea / Sleep Disordered Breathing
Please check if any of the following apply:

- ☐ Patient currently on nocturnal oxygen?**
- ☐ Patient currently on PAP?** (CPAP, BiPAP, other)
- ☐ Yes ☐ No**Can O2 / PAP therapy be **removed during the test?**

**IDS cannot perform home sleep tests on PAP or O2

- ☐ Test to evaluate dental appliance
- ☐ Test is to evaluate post-surgery OSA
- ☐ Test to evaluate OSA following weight loss
- ☐ Other:

4 Diagnosis:

Obstructive Sleep Apnea (ICD10: G47.33) will be used unless otherwise specified below.
Additional/Other Diagnosis: ICD10: _____ . _____ Description: _____

NOTE: Many payors **require OSA dx for coverage** ☐ Check if additional diagnosis above is to replace OSA diagnosis

5 Medical History: *Complete and/or attach supporting chart notes. Required by many payers for authorization!

SYMPTOMS/MARKERS: Check ALL that apply. Some payors require 2 and some up to 4 to determine medical necessity for coverage.

- ☐ Observed Apneas
- ☐ Daytime Sleepiness
  Epworth Score: _____
- ☐ Habitual/Disruptive Snoring
- ☐ Non-Restorative Sleep
- ☐ Obesity (BMI > 30)
- ☐ Hypertension, Uncontrolled
- ☐ Choking/Gasping during sleep
- ☐ Inappropriate napping
- ☐ Morning Headaches
- ☐ Craniofacial or upper airway soft tissue abnormalities
- ☐ Large Neck (>17" M, 16" F)

COMORBID CONDITIONS: Check all that apply

- ☐ COPD - Mod to Severe
- ☐ CHF (NYHA class III or IV)
- ☐ Recent stroke or TIA (last 30-days)
- ☐ Neuro-degenerative disorder/weakness
- ☐ Significant, persistent cardiac arrhythmia
- ☐ Obesity hypoventilation syndrome
- ☐ Chronic Opiate Narcotic Use

- None checked denotes none present

OTHER SUSPECTED SLEEP DISORDERS:

- ☐ Narcolepsy
- ☐ Nocturnal seizures
- ☐ Central Sleep Apnea
- ☐ Hyper or Parasomnias
- ☐ Restless Leg (PLMD)

6 Ordering Physician Info & Signature * Indicates required fields

*NPI: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (**PHYSICIAN'S INDIVIDUAL NPI REQUIRED!!! Physician/PA/NP only)

*Last Name, First Name:

Address, City, State, Zip:

*Fax, Phone:

I, the undersigned, authorize Instant Diagnostic Systems to perform a Home Sleep Apnea Test on above patient. I certify that I am the physician identified on this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify that this order is not for screening an asymptomatic patient and that CMS coverage requires a prior face-to-face encounter with documented symptoms of Obstructive Sleep Apnea. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. The patient's medical record contains supporting documentation that substantiates medical necessity of the prescribed testing and the physician notes and other supporting documentation will be provided to Instant Diagnostic Systems upon request. I understand any falsification, omission, or concealment of material fact in any section may subject me to civil or criminal liability. A copy of this order will be retained as part of the medical record.

Sign Here: X _____ Date: __/__/_____

Stamped Signatures Not Accepted

Fax with Supporting Chart Notes & Insurance Card to IDS: (888)771-5159

Questions? Call IDS: 800-355-0691

Rev: 9/23/2015

Home Sleep Test Patient Guide

Physicians: Please give your Home Sleep Test patient a copy of this flyer.

IDS
Instant Diagnostic Systems™

Dear Home Sleep Test Patient,

Your physician has prescribed a Home Sleep Test to evaluate you for a condition called Sleep Apnea.

Instant Diagnostic Systems (IDS) is the lab that will contact you to schedule your home sleep test, provide the home sleep test equipment, and process your test results.

What is a Home Sleep Test?

A home sleep test is a simple-to-perform diagnostic procedure you will take in the comfort of your own home.

While you sleep, the home sleep test device monitors your breathing and records pauses in your breathing known as Apneas.

What is Sleep Apnea?

Sleep Apnea is a condition where you stop breathing during sleep. An individual with sleep apnea may not be aware of having this difficulty breathing.

Untreated, sleep apnea can lead to excessive daytime sleepiness and fatigue, as well as serious health problems such as high blood pressure, heart problems, diabetes and stroke. The good news is, however, that treatment options are available for every sleep apnea sufferer!

What to Expect:

1. IDS will call you to schedule the delivery of the Home Sleep Test equipment kit.
2. This test kit will typically arrive in 2-3 days.
3. Take the home sleep test the first night after receiving the device. Go through your regular evening and bedtime routines to make sure you get your normal night's sleep.
4. Fill out the required paperwork and return the device in the prepaid shipping package to any outgoing U.S. Postal Service mailbox the very next day.
5. When IDS receives the device, the data will be processed and reviewed by a board certified sleep physician and a report will be sent to your physician, with whom you will discuss the results.

Test Scheduling Tips:

When IDS calls, the following information will be required to schedule your test:

- **Your address**
- **Date of birth**
- **Current/accurate height and weight**
- **Current insurance card(s)**

To learn more, contact IDS at

1-800-355-0691

(Choose Option 1)

IDS001A February 2011