WWW.SOUNDSLEEPHEALTH.COM

Home Sleep Test Referral Form

Patient Information

Name (Last, First, MI)____ Date______________

Phone (____)______________________ Date of Birth____/___/____

Ordering Physician (please print):

Name____Phone______________________________

I the undersigned certify that by signing below that I am ordering Home Sleep Test for the patient listed above. I certify that this order is not for screening purposes for a asymptomatic patient. I also understand Medicare coverage guidelines require a face to face clinical evaluation for sign/symptoms of Obstructive Sleep Apnea to be documented in the patient's medical record prior to a home sleep test.

Physician Signature___________________________________**Date**______________

G.A.S.P. Questionnaire

Yes	No	Not Sure	
☐	☐	☐	Have you been told (or noticed on your own) that you snore on most nights?
☐	☐	☐	Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep?
☐	☐	☐	Are you tired, fatigued or sleepy on most days?
☐	☐	☐	Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?
☐	☐	☐	Are you overweight?

Medical staff will fill this part out:

☐ + ☐ = | 0 | 1 | 2 | 3 | 4 | 5 |

Fax Form to Sound Sleep Health:
Kirkland - 425.636.2401 or Northgate – 206.367.4399

Questions? 877.506.REST (7378) www.soundsleephealth.com