Prescription /Letter of Medical Necessity

AMERICAN SLEEP CENTERS

Ordering Physician _____
Physician's Address_____
Phone _____Fax:_____

Supplier : Americansleepcenters.com * 9439 W Archibald ave. #105 Rancho Cucamonga, CA 91730
Supplier Information Fax 1-888-553-3077 * 909-987-5510
CA License 56879TX Tax ID 203626682

Date:_____

Diagnosis ICD-10:
O G47.33 Obstructive Sleep Apnea (OSA) (Adult and Child) O Other _____
O Secondary condition (if AHI/RDI is 5–14) _____
Estimated length of need _____ months (99 = lifetime) E1390 Oxygen; bleed in at _____ LPM

Patient Name: _____ DOB: _____

Patient Address: _____
Street City State Zip

Phone (H): ____ (W): _____ (Cell): _____

Humidifier(s) O Patient Preference Heated Humidifier (E0562)
O Passover Humidifier (E0561) O Heated Humidifier (E0562)

CPAP Mask/Interface/Delivery System:
O CPAP Mask, Patient Preference

Select ONE only:

E0601 CPAP _____ cmH2O (4–20 cmH2O) Ramp time _____ min(s) (OFF–45 min) OR Check box to adjust to patient comfort

E0601 Auto Adjusting CPAP with settings of 4–20 cmH2O with comfort settings

E0601 Auto Adjusting CPAP with settings of _____ cmH2O to _____ cmH2O with comfort settings (4–20 cmH2O)

E0470 Bi-level IPAP _____ cmH2O (*4–25 cmH2O) EPAP _____ cmH2O (*4–25 cmH2O)

E0470 Auto Adjusting Bi-level Max IPAP 25 cmH2O; Min EPAP 4 cmH2O; PS 4 cmH2O

E0470 Auto Adjusting Bi-level Max IPAP _____cmH20 Min EPAP _____cmH20 PS_____(0-10cmH20)

The following dispensable equipment is necessary for the proper use of the equipment and is not a part of the CPAP, BiLevel, BiLevel ST, BiLevel SV or AVAPs machine when purchased and needs to be replaced on a regular basis:

Full Face Mask (A7030)
Full Face Cushion (A7031)
Nasal Mask (A7034)
Mask Cushion (A7032)
Nasal Pillows (A7033)
Headgear (A7035)
Chinstrap (A7036)
Tubing (A7037)
Disposable Filters (A7038)
Heated Humidifier Tubing w/ Heating Element (A4604)
Oral Interface (A7044)
Exhalation Port/Swivel (A7045)
Humidifier Chamber (A7046)
Non-Disposable Filters (A7039)

Physician's Signature: _____ NPI:_____
Date:_____ License:_____

Please fax to: 1-888-553-3077

O I would like free educational material sent to my office regarding Sleep Apnea and CPAP for my patients
O Do not fax me further prescription requests on behalf of patients. Opt out fax: 1-888-553-3077

Sleep Questionnaire

AMERICAN SLEEP CENTERS

Dear Patient,

Your Doctor is screening for sleep apnea with the below questionnaire and may recommend you for a sleep study. If you are recommended for a sleep study by your Doctor, the *Sleep Lab* will contact you directly to schedule your study and verify your insurance. Thank you.

Name: _____ Height: _____ Weight: _____

Insurance: _____ Age: _____ D.O.B.: _____

Home Phone: _____ Cell: _____ Email: _____

CHECK THE FOLLOWING THAT APPLY:

- ☐ High Blood Pressure
- ☐ Coronary Artery Disease
- ☐ History of Stroke
- ☐ Congestive Heart Failure
- ☐ Insomnia
- ☐ Mood Disorders
- ☐ Chronic Fatigue

			Points
Have you been told that you stop breathing while asleep?	☐ Yes	☐ No	8
Have you ever fallen asleep or nodded off while driving?	☐ Yes	☐ No	6
Do you awaken suddenly with shortness of breath, gasping or with your heart racing?	☐ Yes	☐ No	6
Do you feel excessively tired during the day?	☐ Yes	☐ No	4
Has anyone ever told you that you snore while you are sleeping?	☐ Yes	☐ No	4
Have you had weight gain and found it difficult to lose ?	☐ Yes	☐ No	2
Have you taken medication for or been diagnosed with high blood pressure?	☐ Yes	☐ No	2
Do you kick or jerk your legs while sleeping?	☐ Yes	☐ No	3
Do you feel burning, tingling, or crawling sensations in your legs while you are awake?	☐ Yes	☐ No	3
Do you wake up with headaches during the night or in the morning?	☐ Yes	☐ No	3
Do you have trouble falling asleep?	☐ Yes	☐ No	4
Do you have trouble staying asleep once you fall asleep?	☐ Yes	☐ No	4

Score & Risk Factor: _____

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

Thank You!

Sleep Questionnaire

Dear Patient,
Your Dentist is screening for sleep apnea with the below questionnaire and may recommend you for a sleep study. If you are recommended for a sleep study by your Dentist, the *Sleep Lab* will contact you directly to schedule your study and verify your insurance.

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder. This questionnaire is not meant to be used as a substitute for any diagnostic procedure.

Name:_____ Height:_____ Weight:_____

Insurance:_____ Age:_____ D.O.B.:_____

Home Phone:_____ Cell:_____ Email:_____

Check all that apply

___Enlarged/Scalloped Tongue
___Gastroesophageal Reflux
___Hypertension
___Heart Failure
___Retruded Lower Jaw
___Enlarged Tonsils
___Atrial Fibrillation
___Stroke
___High Arching Hard Palate
___Metabolic Syndrome
___Diabetes
___Bruxism

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Score & Risk Factor: _____

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RX

___Overnight Sleep Study
___Referral to Primary Care Physician
___Referral to Board Certified Sleep Physician
___No Indication (6 month re-evaluation)

Dr. Signature:_____

Sleep Questionnaire

Ph: 866.987.1611 Fax: 909.987.5510

AMERICAN SLEEP CENTERS

Dear Patient,
Your Dentist is screening for sleep apnea with the below questionnaire and may recommend you for a sleep study. If you are recommended for a sleep study by your Dentist, the *Sleep Lab* will contact you directly to schedule your study and verify your insurance.

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Home Phone: _____ Cell: _____ Email: _____

Check all that apply

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Score & Risk Factor: _____

Low	Moderate	High	Severe
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RX ☐ **I would like to have someone contact me for a Home Sleep Study for a possible Oral Appliance Therapy.**

___Overnight Sleep Study ___HST ___Referral to Primary Care Physician
___Referral to Board Certified Sleep Physician ___No Indication (6 month re-evaluation)
Dentist Signature: _____

Sleep Questionnaire

Name:_____ D.O.B._____AGE:_____

Insurance:_____ Phone:_____ Ht:_____ Wt:_____

Circle all that apply:

High Blood Pressure	Heart Disease	Diabetes
Restless Leg Syndrome	Sleep Apnea	Insomnia
Narcolepsy	Depression	Anxiety /PTSD
Recent Head Trauma	Stroke	Neurological Disorder
Pain Condition	A.M. Headaches	Night Sweats

Sleep: (Circle One)

Have you been told that you stop breathing while asleep?	YES	NO
Have you ever fallen asleep or nodded off while driving?	YES	NO
Do you awaken suddenly with shortness of breath, gasping or with your heart racing?	YES	NO
Do you feel excessively tired during the day?	YES	NO
Has anyone ever told you that you snore while you are sleeping?	YES	NO
Do you feel burning, tingling, or crawling sensations in your legs while you are awake?	YES	NO

Insomnia: (Circle One)

Difficulty falling asleep	None	Mild	Moderate	Severe	Very Severe
Difficulty staying asleep	None	Mild	Moderate	Severe	Very Severe
Problem waking up too early	None	Mild	Moderate	Severe	Very Severe

Do you have vivid or troubling nightmares?

Never Rarely Sometimes Frequently Almost Always

How often do you take a prescription medication to help you fall sleep or stay asleep?

Never Rarely Sometimes Frequently Almost Always

How often do you take an 'Over the Counter' medication to help you fall asleep or stay asleep?

Never Rarely Sometimes Frequently Almost Always

Cardiac: (Circle One)

Do you smoke?	YES	NO
Do you elevated cholesterol or triglycerides?	YES	NO
Do you have varicose veins?	YES	NO
Do you ever stand up and get light headed?	YES	NO
Do you have erectile dysfunction? (men)	YES	NO
Do you have heart palpitations or heart "flutters"?	YES	NO
Have you ever had a sudden loss of vision in one eye, usually lasting only seconds?	YES	NO
Do you have, or easily get, cold hands or feet?	YES	NO
Do you have gum disease, gingivitis, or periodontitis?	YES	NO
When walking or exercising, do you get leg pain or cramping?	YES	NO

Weight Loss:(Circle One)

Is your BMI over 39?	YES	NO
Do you feel tired during the day?	YES	NO
How many times per week do you exercise? _____		
Do you need to lose 20lbs more?	YES	NO
Have you had weight gain and found it difficult to lose?	YES	NO

Patient Signature_____ Date:_____

AMERICAN SLEEP CENTERS

Weight Loss Sign - In

Date:	Name:	Time - In:	Time - Out:	Signature: