CORRECTIONAL MEDICAL GROUP SLEEP TEST ORDER FORM

DROPSHIP ONLY

Do not use if you dispensed a recorder from office

FAX form to: 847-465-3401

PATIENT NAME:		**DOB:**	**INMATE ID # :**	
Address:		City:	State:	Zip:
Height:	Weight:	Neck Size:	Gender:	

MEDICAL ORDER (This section outlined in **BOLD** may be replaced by an *approved* Electronic Medical Order)

Provider Name:	Address:
Name of Practice:	City:
Phone:	State: Zip:
Fax [to send patient test results]: ( )	E-mail:

Based on the patient medical history and clinical physical examination, I believe this patient is clinically indicative for and that it is medically necessary to perform an immediate Sleep Study. I order the following test from SNAP Diagnostics:
Test Ordered: Default to Sleep Apnea X 3 nights or ☐ Other ______ ICD-10 code: Default to G47.30 or ☐ Other code: ______

Provider Signature: **Date of Order:** PLEASE SIGN & DATE

Patient Clinical Indications and Medical History Details (Check all that apply for the Patient)

☐ Witnessed apnea (stop breathing when sleeping for longer than 10 seconds)
☐ Non-restorative, disturbed or restless sleep
☐ Excessive Daytime Sleepiness
☐ Disruptive Snoring
☐ Gasping / Choking
☐ Atrial fibrillation (AFIB)
☐ Hypertension / High Blood Pressure
☐ Daytime Fatigue
☐ Moderate or Severe COPD
☐ CHF
☐ OHS (If OHS must provide daytime $PaCO_2$ ______)
☐ Neurodegenerative Disorder or Cognitive Impairment
☐ OTHER: ______________________________

Complete this section ONLY if Re-testing the Patient **Prior DX of Apnea?** ☐ No ☐ Yes (if yes, Test Date: ______)

A new sleep test is indicated due to (check all that apply):

☐ Weight gain or loss (> 10% or BMI > 5) ☐ Evaluate therapy effectiveness ☐ Evaluate need to continue therapy

Is the test: ☐ Pre or ☐ Post treatment? **Indicate Type of Treatment:** ☐ Surgery ☐ Oral Appliance ☐ PAP ☐ Other

Send Snap Test Report to DME? ☐ Yes DME Name: Fax: ( )

All billing will be completed per the provider agreement executed between CCMG and Snap Diagnostics.

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Thank you for your referral.

WHAT HAPPENS AFTER YOUR REFERRAL

- On receipt of the Required Documentation our support team will ship a Snap Testing Recorder to the address indicated on the other side of this page (the location where the order originated).
- Follow instructions that will be included to complete the sleep test.
- After the testing is completed, follow the instructions that will be enclosed in the sleep test kit to return the recorder to Snap.
- Our professionally trained team will analyze the test data and a medical director will complete a Snap Sleep Test report.
- The Test Report will be faxed to your location and be available on your secure patient portal.

HELPFUL HINTS

The following can help the sleep testing process go smoothly.

- This order form is used when you want Snap to ship a Snap Sleep Testing Recorder to your office. Please do not forget to include the Inmate ID Number.

- The Ordering Medical Provider must complete the Medical Order section of the Sleep Test Referral form, which must be signed and dated by the Provider where indicated on Sleep Test Referral form.

  The Medical Order section on the form can be replaced with an approved Electronic Medical Order from the practice Electronic Health Record system. NOTE: You must still complete all other sections of Sleep Test Referral form.

SUPPORT

Website: SnapDiagnostics.com

Phone: 800.762.7786

Email: Support@SnapDiagnostics.com