DIAGNOSTIC TESTING ORDER FORM

Patient Name: ______________________ **Sex: M** ☐ **F** ☐ **DOB:** ______________

Address: ______________________ **City:** ______________

State: __________ **Zip:** __________ **Phone:** ______________

Primary Insurance: ______________________ **ID#:** ______________

Secondary Insurance: ______________________ **ID#:** ______________

Referral Office: __________ **Phone:** __________ **Fax:** __________ **Attn:** __________

Dx: __________ **Dx:** __________ **Dx:** __________ **Dx:** __________

Home Sleep Test

☐ On Room Air ☐ On Oxygen ☐ One Night ☐ Two Night

Ht: _______ Weight: _______ BMI: _______ Neck Size: ______ (in.) Sleep Epworth Score: _______

DX: ☐ G47.30 ☐ G47.33 ☐ G47.10 ☐ R09.02 ☐ Other: ______________________

Pulse Oximetry Test

☐ Overnight Oximetry ☐ Awake Oximetry ☐ W/Oxygen @ _____ LPM ☐ PAP Device Other: _________

Rest and Exertion Test

☐ 6 Minute Walk Test @ ______ LPM ☐ Conserving Device ______ Setting ☐ Titrate Patient? ☐Yes ☐No

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Physician Name: ______________________ **NPI:** ______________________

Phone: ______________________ **Fax:** ______________________

Physician Signature: ______________________ **Date:** ______________

PLEASE FAX ORDER ALONG WITH PATIENT DEMOGRAPHICS TO

FAX: (866) 316-7824 FL AND GA ONLY

FAX ALL OTHER STATES: (866-624-1411) KY, MS, NC, PA, TX, VA

Any Questions Please Call (877) 202-1191 Corporate Office Ext 301-Kentucky Regional Office Ext 313