Crescent
NEUROLOGY AND SLEEP

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AASM ACCREDITATION

Home Sleep Study (HST) Order Form

(only for patients ≥18 years old)

*Please **fax this form with a copy of insurance card and a recent office note to process scheduling.***

REFERRED BY (Practice and Clinician Name): _____

OFFICE TEL: _____ **OFFICE FAX:** _____

ORDERING CLINICIAN SIGNATURE: _____ **DATE:** _____

REQUEST FOR (check one): ____ **TEST ONLY** ____**CONSULT FIRST** ____ **CONSULT ONLY IF TEST POSITIVE**

PATIENT INFORMATION:

Name:_____**Date of Birth**: _____

Phone: _____ **Address**: _____

Emergency Contact **Name and Relationship**: _____

Emergency Contact Phone Number: _____

Gender: M / F / Non-Binary **Preferred Pronoun**: He / She/ They **Age**: _____ **Height**: _____ **Weight**: _____

REASON FOR HST (check all that apply):

☐ Loud snoring

☐ Witnessed apneas

☐ Excessive daytime sleepiness or Fatigue

☐ Morning headaches

☐ Insomnia or non-restorative sleep

☐ Assessment of Efficacy of Oral Appliance or Surgery

☐ Obesity (BMI ≥30)

☐ Other: _____

LENGTH OF STUDY REQUESTED (circle one): 1 night 2 nights

DIAGNOSIS WITH ICD-10 CODE: _____

Internal Use Only: Patient to fill (1) Patient Instructions, (2) Waiver, and (3) Credit Card Authorization form to schedule