Initial Treatment with APAP/CPAP and Supplies Worksheet: Adult

Patient Name_____ DOB _____ Age _____

Health Plan_____ Member Number _____

Requesting Physician_____ Sleep Study Provider _____

Directions:
Collect patient information from the requesting physician. Submit online (www.ProviderPortal.com) for an instant response.

Order Type:
__ Initial Treatment: APAP/CPAP and Supplies

Primary Suspected Diagnosis _____

Please provide the AHI or RDI, whichever is higher, from the most recent PSG, HST or pre-split portion of a split night. _____

Sleep Study History

Signs and Symptoms – Non Pediatric
(please select all that apply)

___ Excessive daytime sleepiness evidenced by:
- ___ Epworth Sleepiness Scale (ESS) > 10 or,
- ___ Inappropriate daytime napping (during conversation, driving or eating) or,
- __ Sleepiness that interferes with daily activity

__ Impaired cognition
__ Mood disorders
__ Insomnia
__ Documented hypertension
__ Ischemic heart disease
__ History of stroke
__ Cardiac arrhythmias
__ Pulmonary hypertension

Order Type
Is this request for PAP therapy replacing the titration study in a facility? _ Yes _ No _ Unknown

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