NURSING HOME SLEEP TEST ORDER FORM

Prescription and Clinical Evaluation

Fax to: 1-866-763-9505
E-Mail to: sleep@medicinamedical.com
Customer Service: 1-216-351-0224

Patient Information

Name:	Room #	HT/Weight:	DOB:	Gender
Facility Name:				
Facility Address:	City:		State:	Zip
FAX Number:	Phone:			
E-Mail:	Ordered By:			
1) Is patient currently on BiPAP/CPAP?:	What is the current order?:			
2) Is patient long on a short-term rehabilitation stay?				
3) What is the projected discharge date?				

Ordering Provider - Physician/CNP Information

Name:	Fax:	Phone:	UPIN:

Sleep History & Physical Exam (fill in blank and check all symptoms that apply)

☐ Sleep Disordered Breathing ☐ Loud Snoring ☐ Depression ☐ Observed Apnea
☐ Oral Appliance Assessment ☐ Non-Restorative Sleep ☐ Gasping/Choking ☐ Dry Mouth
☐ Excessive Daytime Sleepiness ☐ Morning Headaches ☐ Dry Mouth in A.M.

Cardiopulmonary/Upper Airway Exam (Check all that apply)

☐ Nasal Obstruction ☐ Enlarged Tongue ☐ Obesity
☐ Teeth Worn ☐ Crowded Hypopharynx ☐ Hypertension
☐ Maxillomandibular Abnormalities ☐ Crowded Oropharynx ☐ Retrognathia Micrognathia
☐ Over/Under Bite ☐ Enlarged Tonsils

Diagnostic Codes

☐ G47.30 Sleep Apnea, Unspecified ☐ R09.02 Hypoxemia
☐ G47.30 Hypersomnia with Sleep Apnea, Unspecified ☐ G47.30 Organic Sleep Apnea, Unspecified
☐ G47.30 Insomnia with Sleep Apnea, Unspecified ☐ G47.33 Obstructive Sleep Apnea, Adult Pediatric
☐ Other:

Home Sleep Test Procedure

1 or 2 night unattended, type III Portable recording with minimum four (4) channels: Records airflow, respiratory effort, 02 saturation and heart rate performed on room air unless specified below.

TEST TO BE PERFORMED UNDER THE FOLLWING CONDITIONS;

☐ Test on Room Air – check here if test is to be performed without oxygen and on room air.

☐ Test on Oxygen – check here if test is to be performed with patient on oxygen.

☐ What are the current oxygen orders? _________ Continuous or PRN?________________

***** PLEASE NOTE: ALL TESTS ARE PERFORMED WHILE PATIENT IS OFF BIPAP/CPAP THERAPY *****

Equipment Loan Agreement-Medicina Medical & CleveMed

This agreement is between the Facility, Medicina Medical and CleveMed (sleep lab).

Terms and Conditions of Equipment Loan

1. CleveMed will lend the equipment to the facility on the terms and conditions of this agreement.
2. The equipment shall be loaned from ____________ until ______________.
3. The equipment loan period may be extended by mutual consent of both parties
4. No variation or amendment of this agreement will be effective unless it is made in writing and approved by the Director of CleveMed Operations.

Collection and Delivery of Equipment

CleveMed will send via United States Postal Service (or other carrier of choice) equipment to be used for the Home Sleep Test.

Title and Risk

1. Title and all rights to the equipment shall at all times remain with CleveMed. The patient acknowledges that it has no right, title or property in the equipment.
2. CleveMed will have the equipment checked to ensure it is fit for purpose prior to collection.
3. Risk of any loss or damage to the equipment will become the responsibility of the facility upon receipt of the device and shall not revert back to CleveMed until the equipment is back returned to CleveMed.

Cleanliness

The equipment will be appropriately cleaned prior to the loan period by CleveMed staff.

Requestor Obligations

1. Provide the facility clinical staff with patient with operating and training instructions as appropriate.
2. Provide the necessary additional information (printed material) about the correct use of the equipment and customer support.

The FACILITY undertakings

The facility borrowing the equipment agrees that during the loan period it shall:

1. Keep the equipment in its possession and control and ensure that it is secure against loss, damage and theft.
2. Operate the equipment in accordance with any operating instructions issued for it and for the purpose it was designed.
3. Keep the equipment in good working order.

Lost or Damaged Equipment

In the event of the equipment being lost or damaged the facility agrees to pay the replacement cost ($2,400.00) to CleveMed. Medicina Medical will provide CleveMed with personal information to allow billing for the equipment.

Facility Authorized Name: ____

Signature: ____

Date: _________________

Please fax form, face sheet & signed equipment loan forms to: 1-866-763-9505