Order for One Night Home Sleep Study through Dr. Abaluck

Please gather the information below whenever possible. If the patient is not available to complete the Epworth Sleepiness Scale below, we can contact him or her to complete that scale.

Thank you, Dr. Brian Abaluck. 462 E. King Rd, 1st Floor. Malvern, PA 19355. 484-888-0091. brianabaluck.com

Patient Section

Patient name			DOB	
Preferred phone			patient email:	

Epworth Scale- How likely are you to doze off or fall sleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

situation	chance of dozing (0-3)	situation	chance of dozing (0-3)
Sitting and reading		Lying down to rest in the afternoon when circumstances permit	
Watching TV		Sitting and talking to someone	
Sitting, inactive in a public place		Sitting quietly after lunch	
As a passenger in a car for an hour without a break		In a car, as a driver, stopped for a few minutes in traffic	

Provider Section

Please select a study type: [ ] Home sleep test, G0399		Please select a diagnosis code: [ ] obstructive sleep apnea, g47.33	
Clinical features			Do you want a consult as well? Please select one option below.
[ ] habitual, loud snoring	[ ] witnessed pauses in breathing	[ ] acid reflux during sleep	[ ] Sleep study, then consult
[ ] excessive daytime sleepiness	[ ] sleepiness that interferes with activity	[ ] inappropriate napping	[ ] Sleep study, no consult
[ ] unrefreshing sleep	[ ] morning headaches	[ ] memory loss	[ ] Sleep study, consult if positive
[ ] insomnia	[ ] frequent unexplained arousals from sleep	[ ] erectile dysfunction	Height Weight
[ ] frequent urination at night	[ ] collar size greater than 17" in male or greater than 16" in female	[ ] refractory hypertension	BMI
Provider Name (printed)			Today's Date
Provider Signature			

Office Staff Section

With this form, please send us patient contact information, insurance information, and most recent office note (including medication list). Please fax to 484-253-4407 or send as attachment to sleepdoctor@brianabaluck.com. Please call 484-888-0091 with questions. If the patient has an HMO, and you are the primary care office, consider a navinet referral for cpt g0399- home sleep test- with Dr. Abaluck, group NPI 1962834077.

Please select one of the following:

[ ] The patient does not have an HMO and should not need a referral.	[ ] The patient has an HMO, but we are not the patient's primary care provider. The PCP, if known, is: _____	[ ] The patient has an HMO, and we placed a referral. The referral number, if known, is: _____	[ ] The patient has an HMO, and we will place a referral.	[ ] I'm not sure what kind of insurance the patient has.

Section to be completed upon Dr. Abaluck receiving order

[ ] I, Dr. Abaluck, confirm that this is an appropriate order for a home sleep test. My practice will aim to complete home sleep testing.

[ ] We need the following before we can approve this study:

[ ] I do not approve this home study. I will inform the referring practice of next steps.

Dr. Brian Abaluck Signature	Date