WatchPAT-200
CDL Sleep Study
Prescription / Order

Certificate of Medical Necessity

Patient (Last, First, MI) _____ **Today's Date** _____

Insurance ID#/Carrier _____ **Date of Birth (mm/dd/yyyy)** _____

Patient Address _____ **Home Phone** _____ ( )*

_____ **Cell Phone** _____ ( )*

_____ **Work Phone** _____ ( )*

Email _____ (*indicated preferred method to contact)

Height _____ **Weight** _____ **(or BMI)** _____ **Epworth Score** _____ **Male** ☐ **Female** ☐

☐ **Transportation/Positive ID**
CDL SLEEP STUDY

"HIGH PROBABILITY OF OSA"

(ESS≥10, BMI≥30 & symptoms (√ below))

☐ **Positive ID Bracelet Requested**

ID Bracelet to be applied/attested to by: ☐ **Prescribing Physician**

☐ **Notary Public**

Prescribing Physician: ☐ on file

Name/Title: _____

Address: _____

City:_____ ST:_____

Zip:_____ Phone: _____

Transmit results by:

☐ Fax:_____

☐ E-mail:_____

Does patient have a permanent pacemaker? ☐ **Yes** ☐ **No** **Is the patient on Oxygen?** ☐ **Yes** ☐ **No**

√	**Sleep History / Conditions / Symptoms (check all applicable - at least one)**						
☐	**Loud, Disruptive Snoring**	☐	**Ischemic Heart Disease**	☐	**Impaired Cognition**	☐	**Diabetes**
☐	**Witnessed Apnea > 10 sec. by** _____	☐	**Chronic Fatigue**	☐	**Mood disorders**	☐	**Elongated Soft Palate**
☐	**Gasping or Snorting (During Sleep or Upon Waking Up)**	☐	**Hypertension**	☐	**Insomnia**	☐	**Nasal Obstruction**
☐	**Excessive Daytime Sleepiness**	☐	**History of Stroke**	☐	**Obesity**	☐	**Swollen Turbinates**
☐	**Morning Headache**	**Please List any medications Taken:**					

Primary Diagnostic ICD-10 Code (check only one)					
☐	**G47.33 Obstructive Sleep Apnea (Adult & Pediatric)**	☐	**G47.30 Unspecified Sleep Apnea**	☐	**R06 Primary Snoring**

_____ _____ _____

Physician Signature **Date** **Physician Name (printed)**

☑ By signing below, I acknowledge that I have received and read 1st Line Medical, Inc.'s Privacy, Financial and Responsibilities Policy Statements and agree to participate in the diagnostic service as described, including timely use and return of the testing device.

_____ _____

Patient Signature Date

Submit via FAX #: ***800-918-7860*** Phone Number: 866-720-8080