Smithtown Family Practice

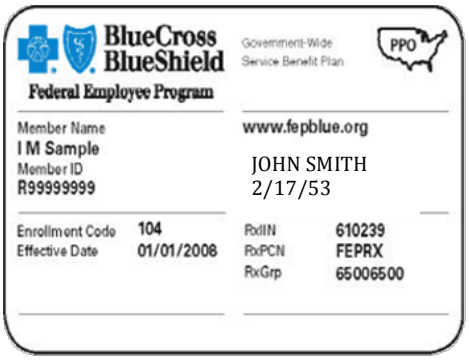
REGISTRATION FORM

Today's Date: 5/6/2014			PCP: [PCP]		
PATIENT INFORMATION					
Patient's last name: Smith	First: John	Middle: JS	[Choose an item]	Marital status: [Choose an item]	
Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name? [Legal Name]	Former name: [Former Name]	Birth date: [Birthday]	Age: [Age]	Sex: ◯ M ◯ F
Address: 1 Neverland Way, Farmington NY 00000					
Social Security no.: 000-00-1000	Home phone no.: 123-456-7890	Cell phone no.: 098-765-4321			
Occupation: Truck Driver	Employer: DOT	Employer phone no.: 102-394-4857			
Chose clinic because/referred to clinic by (Please choose one option): ◯ [Doctor's name] ◯ [Choose an item]					
Other family members seen here: [Other patients]					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill: JS	Birth date: 2/17/53	Address (if different): -Same-	Home phone no.: [Phone]		
Is this person a patient here? ◯ Yes ◯ No		Is this patient covered by insurance? ◯ Yes ◯ No			
Occupation: [Occupation]	Employer: [Employer]	Employer address: [Address]	Employer phone no.: [Phone]		
Please indicate primary insurance: [Choose an item] | Other: [Other insurance]					
Subscriber's name: Empire BCBS	Subscriber's S.S. no.: [SS#]	Birth date: [Birthday]	Group no.: [Group #]	Policy no.: 1AB-23456789Z	Co-payment: $0.00
Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]					
Name of secondary insurance (if applicable): Medicare	Subscriber's name: [Name]	Group no.: [Group #]	Policy no.: [Policy #]		
Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address): Mary Smith	Relationship to patient: Wife	Home phone no.: 123-456-7891	Work phone no.: [Phone]		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Smithtown Family Practice or insurance company to release any information required to process my claims.

John Smith — Patient/Guardian signature

5/6/14 — Date



Name JOHN SMITH DOB 02/17/53 Neck Size 15 Age 56 Gender X M F

Height 6" Weight 160 Address 1 FARLAND WAY, FARMINGTON NY ZipCode 10000 Phone 123-456-7890

Insurance Carrier BCBS ID R999999 Auth # A1234567

Do you smoke X Y N BMI 22.96 Screening Date 5/6/14

If Yes, Are you ready to quit smoking? Y X N

Internal Purposes ONLY
Patient update 1 2 - 3 - 4 - 5 - 6

STOP BANG Screener (Check Yes or No)	YES	NO
S (snore) Do you snore?	X	
T (tired) Do you feel fatigued during the day? Do you wake up feeling like you haven't slept?	X	
O (obstruction) Have you been told you stop breathing at night? Do you gasp for air or choke while sleeping?		X
P (pressure) Do you have high blood pressure or are on medication to control high blood pressure?		X
SCORE: If you checked YES to two or more questions on the STOP portion you are at risk for OSA.		
B (BMI) Is your body mass index greater than 28?		X
A (age) Are you 50 years old or older?	X	
N (neck) Are you a male with neck circumference greater than 17 inches, or a female with neck circumference greater than 16 inches?	X	
G (gender) Are you a male?	X	
SCORE: The more questions you checked YES to on the BANG portion, the greater your risk of having moderate to severe OSA.		

Epworth Sleepiness Scale (Rate with 0 - 3 scale)

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just 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

	0	1	2	3
Sitting and reading				X
Watching TV				X
Sitting inactive in a public place (e.g. a theater or a meeting)				X
Sitting in a car as a passenger for a continuous hour		X		
Lying down to rest in the afternoon when circumstances permit				X
Sitting and talking to someone	X			
Sitting quietly after a lunch without alcohol		X		
Sitting in a car stopped in traffic for a few minutes		X		
TOTAL				

SCORE: 0–10 Normal range 10–12 Borderline 12–24 Sleepy

Patient's History	Yes	No
Patient Screening		
Education		
Patient Take Home		
Date of HST_____		
Device Returned		
Schedule for HST results		

Negative **Mild/Moderate** **Severe**

Total Score: 15

Doctor's Notes:

NEEDS SLEEP STUDY

Post Sleep Questionnaire

To be completed after patient's home sleep test

Study date* 05/06/14

Time you fell asleep* 10:00 PM

Typical duration of sleep* 7-8 HOURS

Duration of sleep* 8 HRS

Current medications* ATACAND

Main sleep complaint*

- [X] Snoring
- [ ] Witnessed apnea (cessation of breath while sleeping)
- [X] Excessive daytime sleepiness
- [ ] Other (explain in detail)

Medical history*

HYPERTENSION

The patient is responsible for returning the device in the same condition as it was received. The patient understands that they liable for any damage, loss or failure to return the above device on the assigned return date: 05/ 07 /14. Failure to comply may result in the assessment of a late charge.

Signature: JOHN SMITH

Print Name: JOHN SMITH

INTERPRETATION LETTER

Physician Practice, 4415 Euclid Avenue, Cleveland, Ohio 44103

Patient Name: John, Smith.
Study Date: 05/06/14
Referred by: Dr. Ordering

PATIENT INFORMATION:
This 56-year-old M was referred for a type 3 portable sleep study. The following were the reasons and indications: restless sleep and snoring.

Height was 70.00 inches and weight was 160.00 Lbs, which represented a BMI of 22.96. Patient has Epworth score of 15/24. Past medical history consisted of: Hypertension. Medication list included: Atacand.

PROCEDURE:
The patient underwent a digital diagnostic portable type 3 device home sleep test; Utilizing CleveMed's SleepView device. We simultaneously recorded airflow via thermistor for apneas, and a nasal pressure transducer for hypopneas. Thoracic respiratory efforts were recorded via respiratory inductance plethysmography. Position monitoring was obtained via an accelerometer integrated in the SleepView device.

Also obtained was pulse oximetry, to identify oxygen desaturations. All of these channels were graphically recorded and documented to provide signals of high enough quality to provide accurate conclusions.

The patient underwent one night of study (although the capacity for multiple night was present). The data was recorded internally to memory built into the SleepView unit and was uploaded to CleveMed's eCrystal PSG website for scoring and interpretation. All raw data, in the form of nearly one thousand complete 30 second epochs, graphically depicting all seven channels, were utilized for scoring and detailed interpretive review. The standards put forth by the American Academy of Sleep Medicine were followed for the complete scoring by a Sleep Technologist and interpretation by a Board Certified Sleep Medicine Physician.

SLEEP TIME AND EFFICIENCY:
The sleep study recording began at 09:58:24 PM and ended at 06:05:22 AM. Total recording time was 486.9 minutes. The patient's own estimate of sleep time was 8 hours. This provides an estimated sleep efficiency of 100%.

RESPIRATORY DATA:
Moderate snoring was noted. There were 118 respiratory events consisting of 85 apneas (73 obstructive and 12 suspected central episodes) and 33 hypopneas. The Respiratory Disturbance Index (RDI) was 14.5 events per hour, i.e. 14.5 apneas and hypopneas occurred per hour of recording time.

The patient spent 244 minutes on-back, and spent 243 minutes off-back. The Back-Index (RDI) was 23.8 per hour of recording time. The Off-Back RDI was 5.2 per hour.

Patient's baseline O2 saturation was 96.3%. The patient spent 2.1 minutes at an oxygen saturation less than 90%, and 0.08 minutes less than 85%. The desaturation index was 15.6. The lowest saturation was 84.0%.

PULSE RATE REVIEW:
The mean heart rate was 62 beats per minute. The rate ranged from a low of 51 to a high of 84 beats per minute.

DIAGNOSIS PER ICD-9 CODE:
Obstructive Sleep Apnea (OSA) – 327.23

OVERALL IMPRESSION:
Moderate Obstructive OSA, worsened in the supine position. Likely contributing factor to his HPT

RECOMMENDATION:
Cpap Titration Sleep Study in the sleep lab
Then Long Term CPAP therapy w/ a comfortable leak free mask

If CPAP is not tolerated or feasible, an Oral Appliance should be considered.
After 3mos of use, the home test should be repeated with the appliance in place, to document efficacy

Sleep Physician

PORTABLE MONITOR REPORT

CleveMed

Cleveland Medical Devices Inc.

Cleveland Medical Devices Inc. 4415 Euclid Avenue, Cleveland, Ohio 44103

Patient Name:	Smith, John	**Height:**	70.00 inches	**DOB:**	2/17/1953
Recording Date	05/06/14	**Weight:**	160.00 Lbs	**Gender:**	M
Physician:	Sleep Physician	**BMI:**	22.96	**Technician:**	Martin Jones
		Neck Size:	15 inches		

RECORDING SUMMARY:

Acquisition Start:	09:58:24 PM	**Acquisition End:**	06:05:22 AM
		Total Acquisition Time:	486.9 min

RESPIRATORY SUMMARY

O. Apnea Events:	73	**O. Apnea Index:**	8.99
***Likely* C. Apnea Events:**	12	***Likely* C. Apnea Index:**	1.48
Total Number of Apnea Events:	85	***Total Apnea Index:***	10.5
O. Hypopnea Events:	27	**O. Hypopnea Index:**	3.33
Total Number of Hypopnea Events:	33	***Total Hypopnea Index:***	4.1
TOTAL NUMBER of EVENTS:	118	***TOTAL APNEA/HYPOPNEA INDEX:***	14.5
Longest O. Apnea Duration:	72.31 sec	**Longest O. Hypopnea Duration:**	84.62 sec
Mean O. Apnea Duration:	33.09 sec	**Mean O. Hypopnea Duration:**	29.82 sec

SLEEP APNEA SEVERITY SCALE

Normal	Mild	Moderate	Severe
AHI <5	AHI 5-14	AHI 15-29	AHI 30 or >

APNEA / HYPOPNEA EVENTS by BODY POSITION:

Position:	SUPINE	PRONE	LEFT	RIGHT	UPRIGHT
Number:	97	0	3	18	0
Index:	23.81	0.0	5.75	5.84	N/A

DESATURATION SUMMARY TABLE

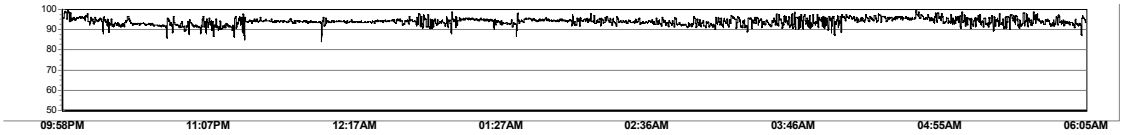
	90+	90-80	80-70	70-60	60-50	50-40	40-
Mins:	476.22	10.25	0.0	0.0	0.0	0.0	0.0
% Time:	97.79	2.10	0.0	0.0	0.0	0.0	0.0

Baseline Sa02 %:	96.3 %	**Lowest Sa02 %:**	84.0%

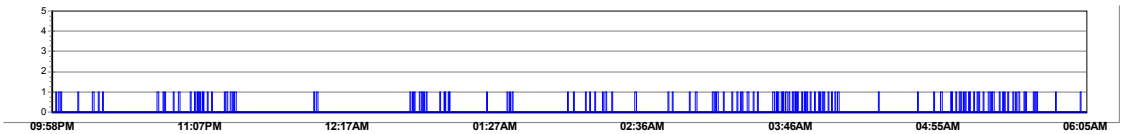
PULSE RATE SUMMARY

Mean Heart Rate (bpm):	62
Minimum Heart Rate (bpm):	51
Maximum Heart Rate (bpm):	84

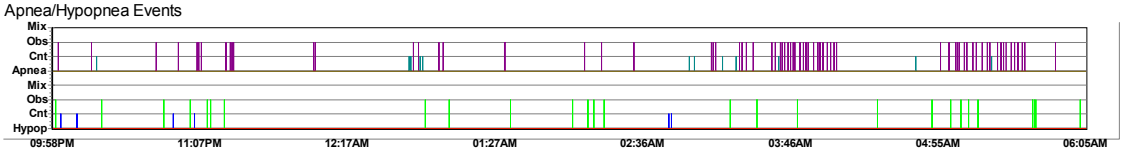
O2 Saturation



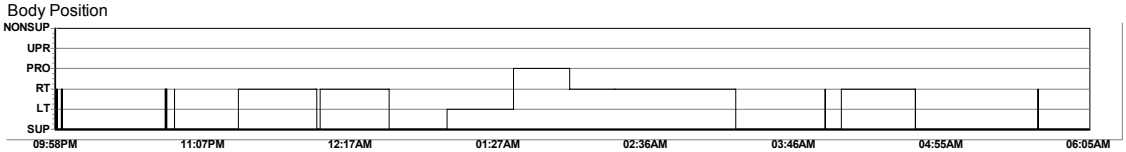
Desaturation Events



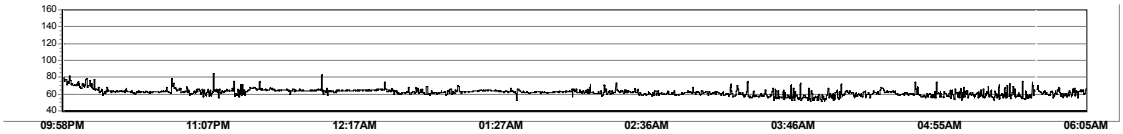
Apnea/Hypopnea Events



Body Position



Heart Rate



Medical Prescription and Statement of Medical Necessity

Patient Demographics

Patient Name: John Smith

DOB: 02/17/53

Address: 1 Farland Way,
Farmington NY 10000

Gender: Male

Patient Insurance

Complete this form & Fax-**up-to-date** patient face sheet

FAX: 855.201.3647

Choose Diagnosis (ICD-9 code must be to the highest level of specificity) (check all that apply)

X	327.23 Obstructive Sleep Apnea
	327.26 Sleep Related Hypoventilation/Hypoxemia
	327.27 Central Sleep Apnea
	Other

PAP Sleep Therapy Prescription	Oral Appliance Prescription	
_____ Auto-CPAP Therapy (E0601)	__X__ Best fit mask	__X__ chin strap
__X__ Minimum CmH_2O = 4 change minimum to _____	__X__ filter	____ full face mask
__X__ Maximum CmH_2O = 20 change minimum to _____	__X__ tubing	____ climate line tubing

LETTER OF MEDICAL NECESSITY

The above referenced patient has a Medical Necessity for the items listed above. I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and medically necessary with reference to the standards of medical practice for this patient's condition.
The duration of the equipment/supplies will be lifetime unless otherwise indicated here

In addition to reviewing the Sleep Study the patient has comorbidities marked below, which require the necessary prescribed items above.

X	Hypertension		Pulmonary hypertension
X	Excessive daytime sleepiness with a Epworth scale of 10 or greater		Impaired cognition or mood disorders
X	Sleepy study findings of AHI		Ischemic heart disease or history of stroke
	Diabetes		BMI > 28
	Witnessed apneas	X	Habitual snoring
	Other: (specify)		

Please sign and date this form. Fax this form, the sleepy study report, insurance card, demographics, prescription & face sheet to 855.201.3647

Physician signature and date

Ordering Provider

Ordering Provider, M.D.
NPI: 12345

P: 123-456-7890

	PHONE	FAX
Please fax over: demographics, insurance card, copy of report and face sheet	855.244.7533	855.201.3647