

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?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
<input type="radio"/> Yes <input type="radio"/> No	[Legal Name]	[Former Name]	[Birthday]	[Age]	<input type="radio"/> M <input type="radio"/> F
Address: 1 Neverland Way, Farmington NY 00000					
Social Security no.:		Home phone no.:		Cell phone no.:	
000-00-1000		123-456-7890		098-765-4321	
Occupation:		Employer:		Employer phone no.:	
Truck Driver		DOT		102-394-4857	
Chose clinic because/referred to clinic by (Please choose one option): <input type="radio"/> [Doctor's name] <input type="radio"/> [Choose an item]					
Other family members seen here: [Other patients]					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):		Home phone no.:	
JS	2/17/53	-Same-		[Phone]	
Is this person a patient here?	<input type="radio"/> Yes <input type="radio"/> No	Is this patient covered by insurance?		<input type="radio"/> Yes <input type="radio"/> No	
Occupation:	Employer:	Employer address:		Employer phone no.:	
[Occupation]	[Employer]	[Address]		[Phone]	
Please indicate primary insurance: [Choose an item] Other: [Other insurance]					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
Empire BCBS	[SS#]	[Birthday]	[Group #]	1AB-23456789Z	\$0.00
Patient's relationship to subscriber: [Choose an item] Other: [Relationship to subscriber]					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Medicare		[Name]		[Group #]	[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):		Relationship to patient:	Home phone no.:	Work phone no.:	
Mary Smith		Wife	123-456-7891	[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.					
<i>John Smith</i>			5/6/14		
Patient/Guardian signature			Date		

Government-Wide
Service Benefit Plan
PPO

Federal Employee Program

Member Name: **IM Sample**

Member ID: **R99999999**

Enrollment Code: **104**

Effective Date: **01/01/2008**

RxIDN: **610239**

RxPCN: **FEPRX**

RxGrp: **65006500**

www.fepblue.org

JOHN SMITH

2/17/53

www.fepblue.org

Federal Employee Program

This card is used to obtain covered benefits under the BlueCross and BlueShield Plan Standard Option.

Prescription is required for all hospital admissions and is ultimately your responsibility. Benefits are reduced by 50% if prescription is not obtained. For assistance, call the local Blue Cross and Blue Shield Plan serving the area where you are insured. In some areas, Preferred hospitals will obtain prescription for you. Certain other services require prior approval. Please consult your benefit Brochure for more information.

Use of this card constitutes acceptance of the terms and conditions in the Service Benefit Plan Brochure (S 71 005) for the applicable contract year which is the only legal description of benefits.

Customer Service: **1-800-522-5566**

Prescription: **1-800-255-2042**

Mental Health/ Substance Abuse: **1-800-626-3643**

Retail Pharmacy: **1-800-624-5060**

Mail Service Pharmacy: **1-800-262-7890**

Assistance Overseas Call Collect: **1-804-673-1678**

Blue Health Connection: **1-888-258-3432**

BlueCross and BlueShield of Geography

An independent licensee of the BlueCross and BlueShield Association.

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	Epworth Sleepiness Scale (Rate with 0 - 3 scale)																																																																																	
S (snore) Do you snore?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<p>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:</p> <p>0 = Would never doze 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing</p> <table border="1"> <thead> <tr> <th></th> <th>0</th> <th>1</th> <th>2</th> <th>3</th> </tr> </thead> <tbody> <tr> <td>Sitting and reading</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>Watching TV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>Sitting inactive in a public place (e.g. a theater or a meeting)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>Sitting in a car as a passenger for a continuous hour</td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Lying down to rest in the afternoon when circumstances permit</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>Sitting and talking to someone</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sitting quietly after a lunch without alcohol</td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sitting in a car stopped in traffic for a few minutes</td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>T (tired) Do you feel fatigued during the day? 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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*

☒ Snoring

☐ Witnessed apnea (cessation of breath while sleeping)

☒ 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



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:

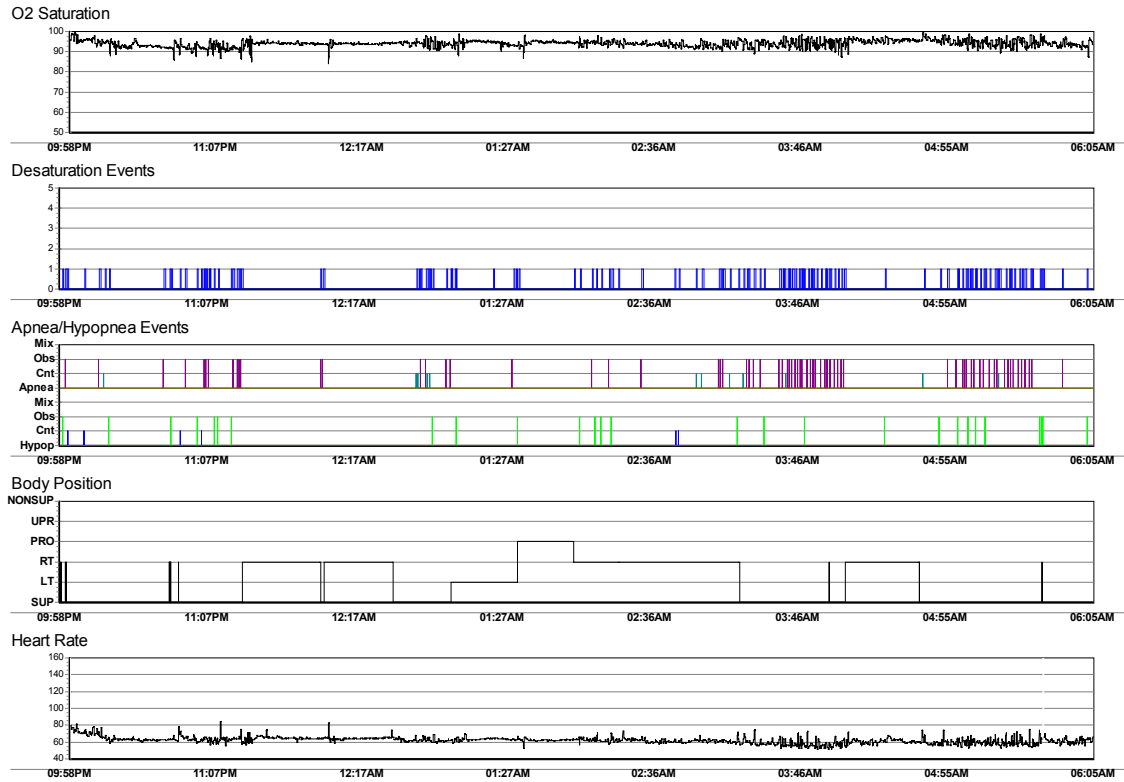
Position:	<u>SUPINE</u>	<u>PRONE</u>	<u>LEFT</u>	<u>RIGHT</u>	<u>UPRIGHT</u>
Number:	97	0	3	18	0
Index:	23.81	0.0	5.75	5.84	N/A

DESATURATION SUMMARY TABLE

	<u>90+</u>	<u>90-80</u>	<u>80-70</u>	<u>70-60</u>	<u>60-50</u>	<u>50-40</u>	<u>40-</u>
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 SaO2 %:	96.3 %		Lowest SaO2 %:		84.0%		

PULSE RATE SUMMARY

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



Oral Appliance: 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)			
327.23 Obstructive Sleep Apnea	780.51 Sleep Apnea (with Insomnia)		
327.26 Sleep Related Hypoventilation/Hypoxemia	<input checked="" type="checkbox"/> 780.53 Sleep Apnea (with Hypersomnia)		
327.27 Central Sleep Apnea	780.51 Intrinsic Sleep Disorder NOS (Upper Airway Resistance Syndrome)		
Other	786.09 Primary Snoring		
This Patient has tried		Please construct and Oral Appliance for this Patient. Special Instructions:	
<input checked="" type="checkbox"/> CPAPA			
Surgery			
Other			
LETTER OF MEDICAL NECESSITY			
<input checked="" type="checkbox"/> The above patient has undergone sleep disorder breathing evaluation. This evaluation confirmed the diagnosis as listed above. This evaluation confirmed that an Oral Appliance is medically necessary. Treatment duration will be up to one year and is expected to be required for the remainder of your subscriber's lifetime. Oral Appliance is used as an alternative to surgery and/or CPAP. If you should have questions, please contact the prescribing physician.			
In addition to reviewing the Sleep Study the patient has comorbidities marked below, which require the necessary prescribed items above.			
<input checked="" type="checkbox"/> Hypertension	Pulmonary hypertension		
<input checked="" type="checkbox"/> Excessive daytime sleepiness with a Epworth scale of 10 or greater	Impaired cognition or mood disorders		
<input checked="" type="checkbox"/> Sleepy study findings of AHI	Ischemic heart disease or history of stroke		
Diabetes	BMI > 28		
Witnessed apneas	<input checked="" type="checkbox"/> 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