Diagnostic Medical Testing
Your Home Medical Visits Provider
Patients Are Our First Priority

DIAGNOSTIC TESTING ORDER FORM

Patient Name: _____ **Sex: M** ☐ **F** ☐ **DOB:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____

Primary Insurance: _____ **ID#:** _____

Secondary Insurance: _____ **ID#:** _____

Referral Office: _____ **Phone:** _____ **Fax:** _____ **Attn:** _____

Dx: _____ **Dx:** _____ **Dx:** _____ **Dx:** _____

Home Sleep Test

☐ On Room Air ☐ On Oxygen ☐ One Night ☐ Two Night

Ht: _____ Weight: _____ BMI: _____ Neck Size: _____ (in.) Sleep Epworth Score: _____

DX: ☐ G47.30 ☐ G47.33 ☐ G47.10 ☐ R09.02 ☐ Other: _____

Pulse Oximetry Test

☐ Overnight Oximetry ☐ Awake Oximetry ☐ W/Oxygen @ _____ LPM ☐ PAP Device Other: _____

Rest and Exertion Test

☐ 6 Minute Walk Test @ _____ LPM ☐ Conserving Device _____ Setting ☐ Titrate Patient? ☐Yes ☐No

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Physician Name: _____ **NPI:** _____

Phone: _____ **Fax:** _____

Physician Signature: _____ **Date:** _____

PLEASE FAX ORDER ALONG WITH PATIENT DEMOGRAPHICS TO

FAX: (866) 624-1411

Any Questions Please Call (877) 202-1191