



## PATIENT INFORMATION

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: (mm/dd/yyyy) \_\_\_\_\_  
 Address / City / State / Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Preferred Written / Spoken Language: \_\_\_\_\_ Emergency Contact / Number: \_\_\_\_\_  
 Primary Payer: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Secondary Payer: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Neck Size: \_\_\_\_\_ Sleep Epworth: \_\_\_\_\_

## PRESCRIBER INFORMATION

Name: \_\_\_\_\_ Address / City / State / Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Referral Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## CARDIOSLEEP TEST (Cardiac & Sleep Test)

**CardioSleep Test:** *Sleep Apnea Test & 1-day Holter & 7-day Mobile Cardiac Telemetry if Holter was unrevealing per policy at www.VirtuOx.net*  
 Cardiac Test Diagnosis:  Palpitations R00.2 Other: \_\_\_\_\_  
 Cardiac Test Symptoms  Chest Pain  Abnormal EKG  Fainting / Near Fainting  General Fatigue Other: \_\_\_\_\_  
 Sleep Apnea Test Diagnosis:  Obstructive Sleep Apnea G47.33  Sleep Apnea Unspecified G47.30 Other: \_\_\_\_\_  
 Sleep Apnea Test Symptoms:  Excessive Daytime Sleepiness  Snoring  Observed Apneas: Other: \_\_\_\_\_  
 Other CardioSleep Test Orders: \_\_\_\_\_

*If patient's insurance carrier does NOT cover MCT, please accept this as my written order for Wireless Event Monitor.*

## CARDIAC ONLY TEST

**Holter Transition to MCT Test:** *1-day Holter & 7-day Mobile Cardiac Telemetry if Holter was un-revealed per policy at www.VirtuOx.net*  
 **Mobile Cardiac Telemetry Test**  3 days  7 days  14 days Other: \_\_\_\_\_ (7 day if not selected)  
 **Wireless Event Monitor Test**  3 days  7 days  14 days Other: \_\_\_\_\_ (7 day if not selected)  
 Cardiac Test Diagnosis:  Palpitation R00.2 Other: \_\_\_\_\_  
 Cardiac Test Symptoms:  Chest Pain  Abnormal EKG  Fainting / Near Fainting  General Fatigue Other: \_\_\_\_\_  
 Other Cardiac Test Orders: \_\_\_\_\_

*If patient's insurance carrier does NOT cover MCT, please accept this as my written order for Wireless Event Monitor.*

## SLEEP APNEA ONLY TEST

**Sleep Apnea Test:** *Room Air up to 2-night unattended portable recorder with min (4) channels eg: records airflow, respiratory effort, POX / HR*  
 Sleep Apnea Test Diagnosis:  Obstructive Sleep Apnea G47.33  Sleep Apnea Unspecified G47.30 Other: \_\_\_\_\_  
 Sleep Apnea Test Symptoms:  Excessive Daytime Sleepiness  Snoring  Observed Apneas: Other: \_\_\_\_\_  
 Other Sleep Apnea Test Orders: \_\_\_\_\_

## INSOMNIA ONLY TEST

**Insomnia Test:** *Room Air up to 2-night unattended portable recorder with minimum three (3) channels eg: EEG, EMG, EOG*  
 Insomnia Test Diagnosis:  Insomnia Unspecified G47.00  Sleep Apnea Unspecified G47.30 Other: \_\_\_\_\_  
 Insomnia Test Symptoms:  Non-Restorative Sleep  Difficulty Falling / Staying Asleep  Waking Up Too Often: Other: \_\_\_\_\_  
 Other Insomnia Test Orders: \_\_\_\_\_

## OVERNIGHT OXIMETRY ONLY TEST

**Oximetry Test:**  **Capnography & Oximetry Test:** *Room Air up to 2-night unattended portable recorder with POX / HR*  
 Oximetry Test Diagnosis:  COPD J44.9  Hypoxemia R09.02  Shortness of breath R06.02 Other: \_\_\_\_\_  
 Oximetry Test Symptoms:  Shortness of Breath  Irregular Heartbeat At Night  Fatigue Other: \_\_\_\_\_  
 Other Oximetry Test Orders:  Room Air  Oxygen  LPM  CPAP/BIPAP Other: \_\_\_\_\_  
 Repeat Overnight Oximetry:  30 Days  60 Days  90 Days Other: \_\_\_\_\_

*\*Please indicate Local Home Health Provider (DME) for this test: \_\_\_\_\_ if left blank, VirtuOx will coordinate to national participating provider.*

## PRESCRIBER SIGNATURE

Click here if ordering physician would like to perform the cardiac testing interpretation (defaults to VirtuOx panel of cardiologists if not checked)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please fax completed order form, demographics & insurance card to **888-635-8380**



## **CardioSleep Testing Ordering Guide**

*It is estimated up to 85% of the patients with AFib also have sleep apnea and patients with sleep apnea have four times the risk of developing AFib. Untreated sleep apnea increases the risk of hypertension which predisposes a person to AFib and other cardiovascular disorders.*

### **CARDIOSLEEP TEST (Cardiac & Sleep Test)**

#### **Holter & Mobile Cardiac Telemetry if needed with Sleep Apnea Test**

- Consider ordering this test if you feel patient has cardiac symptoms like: irregular heart rate, heart palpitations, chest pain, shortness of breath, fatigue or lightheadedness etc... (AND)
- Consider ordering this test if you feel patient has sleep apnea symptoms like: choking or gasping during sleep, excessive daytime sleepiness, observed apneas, snoring or cardiovascular co-morbidities which can cause sleep apnea etc...

### **CARDIAC ONLY TEST**

#### **Holter Transition to MCT, Mobile Cardiac Telemetry or Wireless Event Monitor**

- Consider ordering this test if you feel patient has cardiac symptoms like: irregular heart rate, heart palpitations, chest pain, shortness of breath, fatigue or lightheadedness etc...
- Consider ordering this test to confirm cardiac interventions like surgery, medications etc...

### **SLEEP APNEA ONLY TEST**

#### **Home Sleep Apnea Testing**

- Consider ordering this test if you feel patient has sleep apnea symptoms like: choking or gasping during sleep, excessive daytime sleepiness, observed apneas, snoring or cardiovascular co-morbidities which can cause sleep apnea etc...
- Consider ordering this test for sleep therapy equipment qualification (CPAP, Dental Devices) or to verify settings on sleep equipment are sufficient

### **INSOMNIA ONLY TEST**

#### **Insomnia Testing**

- Consider ordering this test if you feel patient has insomnia symptoms like: difficulty falling asleep, staying asleep or waking up too often etc...
- Consider ordering this test if previous sleep apnea testing was un-revealing (negative OSA)
- Consider ordering this test to verify sleep stages for patients on sleep therapy (CPAP, Dental Devices)
- Consider ordering this test to verify sleep medication ordering, efficiency or titration

### **OVERNIGHT OXIMETRY ONLY TEST**

#### **Overnight Oximetry**

- Consider ordering this test if you feel patient has hypoxemia symptoms NOT associated with sleep apnea like: shortness of breath, cyanosis, morning headache, tachycardia etc...
- Consider ordering this test for oxygen equipment qualification (O2) or to verify settings on sleep equipment (O2, CPAP, Dental Devices)