# KVH Respiratory Care Services
# Home Sleep Apnea Testing

Klickitat Valley Health

Fax: 509-773-3354

## General

Patient Name _____ DOB _____ Phone #_____

Order Start Date _____ Order Expiration Date _____

## Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart notes.
2. Select **Home Sleep Apnea Testing** below

## DIAGNOSIS CODE:

- ☐ **Unspecified Sleep Apnea (G47.30)**
- ☐ **Confirmed Obstructive Sleep Apnea (G47.33)**
- ☐ **Central or other Atypical Sleep Apnea (G47.31, G47.37, G47.39)**
- ☐ **Other: _____**

## Respiratory Care Services Order:

- ☐ **Home Sleep Apnea Testing**

## Ordering Facility/Provider Information:

**By signing below, I affirm the following:**

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

My physician license number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.

**Please Fax Order form to 509-773-3354**

**Provider Signature:** _____ **Date** _____

**Printed name:** _____ **Phone:** _____ **Fax:** _____

**Provider NPI:** _____