WatchPAT® TurnKey

Patient Name:	Office Name:
Patient Mobile Phone:	Referring Provider:
DOB:	Today's Date:

STOP BANG RISK ASSESSMENT:

S (snore) Have you been told that you snore?	**YES / NO**
T (tired) Are you often tired, fatigued, or sleepy during the day?	**YES / NO**
O (obstruction) Do you stop breathing, choke, or gasp during sleep?	**YES / NO**
P (pressure) Do you have or are you being treated for high blood pressure?	**YES / NO**
B (BMI) Is your body index greater than 35 Kg/m²?	**YES / NO**
A (age) Are you 50 years old or older?	**YES / NO**
N (neck) Do you have a neck circumference greater than 16 inches?	**YES / NO**
G (gender) Are you a male?	**YES / NO**
TOTAL STOP/BANG "YES" ANSWERS	

Patient Consent

I am the patient and I understand that I am proceeding with a home sleep apnea test as ordered by my treating physician. I understand that untreated sleep apnea is a serious cardiovascular risk factor and it is my responsibility to perform the test and seek management for sleep apnea. I will be contacted with the results and be managed for sleep apnea by a local sleep physician. **I will be receiving equipment and further instructions by phone. I shall promptly ship back the equipment via the included mailing label. I understand my insurance will be billed for the test and as the patient I am responsible for any insurance related out-of-pocket costs incurred. I have been provided with written instructions and can call for additional video or telephonic instruction, with 24-hour availability of qualified personnel to answer any questions: Patient Help Desk 1-888-748-2627.**

Patient Signature _____ Date_____

☐Patient Telemedicine Verbal Consent

For Office Use Only **Procedure Order Form**

Stop Bang YES 3+ and/or Two Clinical Symptoms - patient qualifies for Home Sleep Test

Submit: This Form + Patient Face Sheet + Clinical Note via CloudPAT or Fax: 512-519-7169

Questions please email: WPT@Itamar-Medical.com

Clinical Note: Will consult Sleep Specialist and refer for management of therapy due to patient increased risk of Sleep Apnea. Ordering a sleep study due to the following two clinical symptoms:

☐Excessive daytime sleepiness (G47.10)	☐Gastroesophageal reflux (K21.9)	☐Nocturia(R35.1)
☐Morning Headaches(G44.221)	☐Difficulty concentrating(R41.840)	☐Fatigue(R53.82)
☐Personality changes or irritability(R45.4)	☐Loud snoring(R06.83)	☐Depression(F32.9)
☐Memory problems/poor judgment(G31.84)	☐Unrefreshed by sleep(G47.8)	☐Impotence(N52.9)
☐History of high blood pressure(R03.0)	☐Sleep Apnea Unspecified(G47.30)	☐Insomnia (G47.00)

☐Diagnostic Services Requested: Diagnostic home sleep test (CPT 95800 or G0400)

Device requested: WatchPAT 200/300/ONE, Manufacturer: Itamar Medical, Other:

Physician/Practitioner Signature: _____ Date: _____

Physician/Practitioner Printed Name: _____ NPI: _____

Address:_____ Phone:_____