



Pt. Sign: _____

Code #: _____

SN: _____

Place SD Card Cover label here
Not applicable when using internet kit
(78-20000)

PATIENT REGISTRATION

Above not applicable when using internet kit 78-20000

Snap Test (Must one): **Postal Mail** **Web Registry** **Drop Ship**

Patient Information					
Name:			Address:		
Date of Birth:		Age:	City:		State:
Zip:		Social Security#:		E-mail address:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Home Phone #:		Cell Phone #:	
Work Phone #:		Height:		Weight:	
Neck Size:		Previously or Currently using PAP: <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently using supplemental oxygen: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Special Conditions on Test Night One:		Special Conditions on Test Night Two:		Special Conditions on Test Night Three:	

Primary Insurance			Secondary / Spouse / Coinsurance		
Insurance Company:			Insurance Company:		
Policy/Group #:		Address:	Policy/Group #:		Address:
Effective Date:		ID # <input type="checkbox"/> PPO <input type="checkbox"/> HMO	Effective Date:		ID # <input type="checkbox"/> PPO <input type="checkbox"/> HMO
Name of Insured (if not Patient):			Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant		
Name of Insured Employer:			Phone:		Years Employed:

Patient Assignment of Benefits and Release Authorization

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to SNAP Diagnostics, LLC (SNAP) all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered by SNAP. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize SNAP to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to SNAP any and all plan documents, insurance policy and/or settlement information upon written request from SNAP in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to SNAP to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from SNAP and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with SNAP in any attempts to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I acknowledge SNAP diagnostics is releasing a Sleep Test Recorder to my possession and that the Recorder is property of SNAP Diagnostics. This recorder is to be returned in operating order by the date indicated by my prescribing practitioner.

I have been trained on the use of the Snap equipment by video, person or written form. I have received a copy of the Notice of Privacy Practices.

Signature of Patient / Guardian

Patient Name (Print)

Date of Service

MEDICAL ORDER



Fax all pages and copy of insurance card to 847-465-3401

OR upload to Snap Cloud

Patient Name: _____

Phone: _____

DOB: _____

Practitioner Information (NOTE: This section outlined in **BOLD** may be replaced by *approved* Electronic Medical Order)

Practitioner Name:	Address:
Name of Practice:	City:
Phone:	State: Zip:
Fax [to send patient test results]:	E-mail:

Based on the patient medical history and clinical physical examination, I believe this patient is clinically indicative for and that it is medically necessary to perform an immediate Sleep Study. I order the following test from SNAP Diagnostics:

Test Ordered: Sleep Apnea X 3

Practitioner Signature:	Date of Order:
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Patient Details (Check all that apply)

Clinical Information:

- Witnessed apnea events during sleep greater than 10 seconds in duration
- Excessive Daytime Sleepiness
- History of Heart Disease
- Craniofacial abnormalities
- Disturbed or restless sleep
- Awaken with headache or dry mouth
- Hypertension / High Blood Pressure
- Upper Airway soft tissue abnormalities
- Diabetes
- Disruptive Snoring
- Gasping / Choking
- Mood Disorder, Fatigue, inability to concentrate
- History of Stroke or family history
- Non-restorative sleep

Co-morbid Conditions:

- Congestive Heart Failure
- Pulmonary Hypertension
- Obesity Hypoventilation Syndrome (If OHS must also provide Daytime PaCO₂ _____)
- COPD/Chronic Lung Disease
- Neuromuscular Weakness
- Cardiac Arrhythmia
- Seizures
- Hx of AMI/Stroke (<6 months)
- Neurodegenerative Disorder or Cognitive Impairment

Evaluate for Post Treatment:

- Were you previously diagnosed with Sleep Apnea? Yes (if yes, move to the next question) No
- Is the re-test *Pre* or *Post* treatment (circle one) Type of Treatment Surgery Oral Appliance PAP Therapy
- Is a new study necessary due to changes in BMI >5 or due to significant weight loss (10% or greater of body weight)
- New study using therapy to evaluate therapy effectiveness New study to evaluate need for continued therapy

Epworth Sleepiness Scale <i>Choose the most appropriate response for each situation</i>	Never would doze off	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
1. Sitting and Reading	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Watching TV	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Sitting inactive in a public place	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. As a passenger in a car for an hour without a break	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Laying down to rest in the afternoon when circumstances permit	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Sitting and talking with someone	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Sitting quietly after a lunch without alcohol	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. In a car, while stopped for a few minutes in traffic	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Score of All Questions (sum total of all eight responses):