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Woodbridge VA 22191

**Ph: 571-261-9877**

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### PHYSICIAN ORDER FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone #'s: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group # \_\_\_\_\_

#### Study orders:

- 95806 **HOME SLEEP STUDY**
- 95810 Diagnostic Polysomnogram Only (sleep Study)
- 95810 Diagnostic Polysomnogram (Sleep Study), with 95811 **CPAP** if indicated
- 95811 Split Night Only (Combined Polysomnogram and **CPAP**/Bi-level Titration)
- 95811 CPAP/Bi-level Titration only
- 95805 MSLT/ MWT (Multiple Sleep Latency Test).
- Sleep Consultation with Doctor

#### Reason(s) for Study and Presenting Symptoms (Please mark all that apply):

- Symptoms:  Witnessed apnea  Hypertension  Loud Snoring  Morning headaches  
 Restless sleep  Obesity  Insomnia  Excessive daytime fatigue  
 Other: \_\_\_\_\_

Suspected  Obstructive Sleep Apnea  Narcolepsy  Restless sleep

Diagnosis:  Parasomnia  Insomnia  Other: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ NPI #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_

#### Referring Physician's Statement:

**I have carefully reviewed this form and find this test to be medically necessary.**

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

**Please fax completed form to (703) 992-9266**