7001 Heritage Village Plaza, Suite # 120 Gainesville, VA 20155
2200 Opitz Blvd, Suite # 335 Woodbridge VA 22191
4216 King Street, Alexandria VA 22302
8101 Hinson Farm Rd, Suite # 318, Mt Vernon, VA 22306
4604 Spotsylvania County parkway, Suite # 310, Fredericksburg, VA 22408
3450 Old Washington Rd, Suite# 202, Waldorf, MD 20602
(**P**) 571-261-9877 (**F**)571-248-0583 (**Email**) cscinfo@commonwealthsleepcenter.com

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 Diagnosis: ☐ Obstructive Sleep Apnea ☐ Narcolepsy ☐ Restless sleep
☐ 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: (571) 248-0583 / (703) 992-9266