2730-D Prosperity Avenue | Fairfax, VA 22031
19465 Deerfield Avenue, Suite 410 | Leesburg, VA 20176
T. 703.226.2290 | F. 703.226.2291
www.fnapc.com/pasc

SLEEP STUDY ORDER FORM

Patient Information

Name: ____ **DOB**: ____________
Last First MI

Phone (home)**:** _____________________ **Phone** (cell): __________________________

PLEASE ATTACH:

- ✓ ***Demographic sheet***
- ✓ ***Insurance information***
- ✓ ***Recent clinical note*** *to include history & physical exam*

Ordering Information for Polysomnogram

Please indicated the type of polysomnogram (PSG) needed:

- ☐ **Diagnostic PSG**, 6 years+ (95810)
- ☐ **Diagnostic PSG**, 3 months to 5 years (95782)
- ☐ **PSG + PAP titration**, 6 years+ (95811)
- ☐ **PSG + PAP titration**, 3 months to 5 years (95783)

Please indicate any/all symptoms present:

- ☐ Snoring
- ☐ Apnea
- ☐ Mouth breathing
- ☐ Daytime sleepiness
- ☐ Frequent awakenings
- ☐ Enlarged tonsils
- ☐ Restless sleep
- ☐ Other ____
____

Suspected Diagnoses:

- ☐ Sleep Apnea
- ☐ Obstructive Sleep apnea
- ☐ Central Sleep Apnea
- ☐ Narcolepsy
- ☐ Hypoxemia
- ☐ Hypoventilation
- ☐ Parasomnia
- ☐ PLMD
- ☐ Other: ____________________

Referring Provider: _____________________ **Phone** ______________ **Fax** __________

Ordering Provider Signature ________________________________ **Date** ____________

Provider Printed Name ________________________ **Practice Name**___________________

Results will be sent to the ordering provider to review with your patient.

Area Below For Sleep Laboratory Use Only

I reviewed the ☐ sleep study order ☐ History and Physical ☐ the sleep study is indicated per criteria ☐ previous sleep study results

Comments: ____
____
____
____
____

Signature: ______________________________________ Date: ______________

S. Haider, MD / A. Vemana, MD / D. Assefa, MD / M.Hawkins, MD