



Tel: 703.385.9222
Fax: 703.385.0882
www.1stclasssleepcenter.com

FAIRFAX

3911 Old Lee Hwy Suite 42-B, Fairfax, VA 22030

VIENNA / MERRIFIELD

2559 Chain Bridge Rd, Vienna, VA 22181

LANSDOWNE

19420 Golf Vista Plaza, Suite 350 & 110, Leesburg, VA 20176

CENTREVILLE

14631 Lee Hwy, Suite 401, Centreville, VA 20121

GAINESVILLE

7915 Lake Manassas Dr, Suite 305, Gainesville, VA 20155

SPRINGFIELD

6128 Brandon Ave, Suite 208, Springfield, VA 22150

Patient Name: _____ Date of Birth: _____

Phone #'s: _____

Address: _____

Insurance: _____

Policy ID: _____ Group # _____

Primary Language: English Spanish Other: _____

Diagnose and Treat for Sleep Disorders – Sleep Study -SPLIT night polysomnogram (if needed), CPAP Equipment arranged for patient (if needed)

Polysomnogram (95810)

CPAP Titration (95811)

SPLIT Night Polysomnogram (95811)

Multiple Sleep Latency Test (MSLT) (95805)

Maintenance of Wakefulness Test (MWT) (95805)

Sleep Consultation with Sleep Specialist

Other: _____

Symptoms

Witnessed Apnea

Loud Snoring

Morning Headaches

Excessive Daytime Fatigue

Other: _____

Hypertension

Insomnia

Obesity

Restless Sleep

Suspected Diagnosis

Obstructive Sleep Apnea

Restless Sleep

Other: _____

Narcolepsy

Parasomnia

Insomnia

Physician Name: _____ NPI #: _____

Physician Address: _____

Physician Phone: _____ Fax#: _____

Physician Statement:
I have carefully reviewed this form and find this test to be medically necessary.

Physician Signature: _____ Date: _____