

CENTRAL VA SLEEP CENTER
AASM ACCREDITED FACILITY
VIKAS GUPTA, M.D. D,ABSM
912 LAFAYETTE BLVD., FREDERICKSBURG, VA 22401
540-656-2811 • FAX 540-479-6961

PHYSICIAN'S ORDER FOR SLEEP STUDY PROCEDURE

CALL REFERRAL # 540-656-2811 *FAX REFERRAL 540-479-6961

(Please print legibly in ink)

Patient _____ Ordering M.D. _____
Diagnosis _____ ICD-9 Code _____ Date of Study _____
SSN _____ DOB _____ Height _____ Weight _____
Insurance Carrier _____ Subscriber # _____ Phone/Contact # _____
Group Name/# _____ Referral or Authorization # (if applicable) _____
Completed by _____ on _____

• SECTION BELOW TO BE COMPLETED BY ORDERING PHYSICIAN ONLY •

Please check all that apply and indicate any conditions or deviations from lab protocols that also apply

- Polysomnogram (PSG)**
- CPAP/BIPAP Titration**
- Split night** if patient meets established protocol
- Multiple Sleep Latency Test (MSLT)**
- Maintenance of Wakefulness Test (MWT)**
- Consult**
- Special Instructions/Comments** _____

• IMPORTANT: please check box below for follow-up: •

- Patient will follow-up with Referral Physician/below**
- Patient will follow-up with Sleep Physician**

*

Patient or Guarantor Signature

Date

*** Please fax completed form and requested information to Central Virginia Sleep Center at 540-479-6961. Form must be filled out and legible. **Please attach any insurance information and last visit office notes or History and Physical.**

Approval by medical director/sleep staff physician _____ date _____