



TESTING SCHEDULE

Fax to 1-800-809-6184

Testing Date M T W TH F S ___ / ___ / ___

Physician Name _____

Office Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact: _____

Please allow 1 hour for a single test, 2 hours for a double test (upper and lower profile on the same patient).

Fax this sheet, Certifications of Medical Necessity, Patient Referral & Intake forms and the patients' insurance cards to 1-800-809-6184. If you have any questions, please call 1-877-268-1346.

TIME	PATIENT NAME	TESTING PROFILE
_____ am	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ am	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ am	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ am	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ am	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ am	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ am	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ am	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____	Please allow time for lunch break	
_____ pm	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ pm	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ pm	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ pm	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ pm	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ pm	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both
_____ pm	_____	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both

FAX THIS FORM TO: 1-800-809-6184