m-health SOLUTIONS

HOME SLEEP APNEA TEST

FaÈ : 1-888-636-0181
Email : info@mhs.healthcare

Please select:

- ☐ Home sleep test only
- ☐ Home sleep test followed by consultation (if necessary)

Clinic Copy
KEEP IN PATIENT FILE

PATIENT INFORMATION					
Name			**Gender**	☐ M ☐ F	
Address			**Unit**		
City			**Postal Code**		
Phone		**Cell**		**Email**	
Health Card Number		**Version Code**		**DOB**	
CC Name		**Fax / Email**			

REASON FOR REFERRAL

☐ Obstructive sleep apnea R/O	☐ Pauses or choking while asleep	☐ Obesity
☐ Central sleep apnea R/O	☐ Grinding/ clenching teeth	☐ Daytime fatigue
☐ Restless sleep	☐ Insomnia	☐ Restless leg/ limb syndrome
☐ Other:	☐ Snoring	☐ Syncope

Medication(s): _____

Special Instructions: _____

REFERRING PHYSICIAN			
Physician Name		CPSO	
Address		Billing #	
Phone		Fax	
Physician Signature		Date	

Note: We must be in contact with your patient to confirm their shipping address & collect payment prior to mailing the device.

m-Health Solutions
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