m-health SOLUTIONS

An ELNA Medical Group Company

HOME SLEEP TEST

E-mail completed form to
info@mhs.healthcare

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

PHYSICIAN'S INFORMATION
Name:
Type: *(dentist/ family doctor, etc)*
Clinic Name/ Address:

REASON FOR REFERRAL

☐ Central Sleep Apnea	☐ OSA suspected	☐ Daytime sleepiness/ tiredness
☐ Restless leg syndrome	☐ Snoring	☐ Insomnia
Pauses or choking while asleep	Tx follow-up	Obesity
☐ Other indications or medical hx:		

Patient Signature:		**Date:**

Note: The cost of this test is $249.00 CAD. We must be in contact with you to confirm shipping address & collect payment prior to mailing the device.

m-Health Solutions
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