m-health SOLUTIONS

HOME SLEEP TEST

PATIENT COPY

PATIENT INFORMATION

Name		Gender: ☐ M ☐ F
Address	Unit	Phone Cell: Home:
City	Postal Code	
Health Card & Version Code:		DOB
E-mail:		

PHYSICIAN INFORMATION

Healthcare Practitioner's Name	Phone
Clinic Name / Address	

REASON FOR ASSESSMENT

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

PRE-EXISTING CONDITION(S)

- ☐ Hypertension
- ☐ Heart Failure
- ☐ Diabetes
- ☐ Stroke
- ☐ Atrial Fibrillation
- ☐ Other Hx/medications:
- ☐ Weight gain
- ☐ Cardiovascular Disease

Please select one of the following:

- ☐ Home sleep test & consult with sleep specialist
- ☐ Home sleep test only

Patient Signature: ________________________________ Date: ____________________

EMAIL REQUISITION TO: info@mhs.healthcare

Home Sleep Test Overview:
1) This study is not funded by OHIP. Patient is required to pay $249.00 +HST (includes shipping & handling).
2) Once shipping address & payment are collected, the device will ship to your home.
3) Test duration is 1-2 nights and the device will be picked up by FedEx via scheduled pick-up.
4) The data is interpreted by a Sleep Physician who will provide a follow up consult

Note: If the equipment is lost or damaged, the patient will be charged for the replacement cost.

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