HOME SLEEP APNEA TEST

PATIENT
SELF-REFERRAL

EMAIL **REQUISITION: info@mhs.healthcare**

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

PHYSICIAN/ PROVIDER INFORMATION		
Provider Name	Registration #	Phone #
Clinic Name & Address		

REASON FOR ASSESSMENT		**PRE-EXISTING CONDITION(S)**	
❑ Central Sleep Apnea	❑ Snoring	❑ Hypertension	❑ Weight gain
❑ Obstructive Sleep Apnea	❑ Insomnia	❑ Heart Failure	❑ Cardiovascular Disease
❑ Pauses or choking while asleep	❑ Obesity	❑ Diabetes	
❑ Daytime sleepiness/ tiredness	❑ Tx follow-up	❑ Stroke	
❑ Restless leg syndrome		❑ Atrial Fibrillation	
❑ Other:		❑ Other medical Hx/medications:	

Please select one of the following:

☑ Home sleep test & consult with sleep specialist

❑ Home sleep test only

Patient Signature: _____ Date: _____

Home Sleep Test Overview:

1) This study is not funded by OHIP. Patient is required to pay $249.00 (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.