m-health SOLUTIONS

PATIENT COPY

HOME SLEEP TEST

6-Channel Type 3 Home Respiratory Recorder for evaluation of sleep-disordered breathing

PATIENT INFORMATION		
Name		Gender: ☐ M ☐ F
Address	Unit	Phone Cell: Home:
City	Postal Code	
Health Card No.		DOB
E-mail:		

PHYSICIAN INFORMATION	
Family Practitioner's Name	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:	

EMAIL REQUISITION TO: info@mhs.healthcare

Thank you for your referral.

Please review the following information:

1. This study is not funded by OHIP. Patient required to pay $350.00 for the loan of equipment & diagnostic report.
2. Patient is required to present a credit card prior to testing.
3. Patient is provided a pre-paid return envelope and is responsible for the safe return of the monitor.
4. If the equipment is lost or damaged, the patient will be charged for the replacement cost.

Patient Signature: _____ Date: _____

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