Sleep Requisition

Sleep Diagnostics and Therapy

Phone: 825-404-8008 | Fax: 825-404-8018

DEEP SLEEP
CLINIC

Patient Information

Patient Label

Last Name: _____
First Name: _____
Sex: F☐ M☐: _____
Date of Birth(MM/DD/YY): _____
Address: _____
Phone: _____
Health Card Number: _____

SLEEP - NO COST AT HOME TESTING

☐ **Sleep Apnea Diagnostics**
Interpreted Home Sleep Apnea Testing (HSAT Level 3)
May Include CPAP treatment, Oral Appliances, Neuromuscular Stimulator

☐ **CPAP Treatment**
Requires previous diagnosis

☐ **Re-Assessment of Treatment**
May include HSAT, CPAP treatment- As indicated

Excite OSA
Neuromuscular Stimulator Treatment

☐ **Other:** _____

Medical History

☐ **Snoring**

☐ **Hypertension**

☐ **Diabetes**

☐ **Cardiovascular Disease**

Referring Physician/ Practioner

Clinic Stamp including #

Name: _____
Signature: _____
Prac ID: _____
Date: _____
Fax Mandatory: _____
Phone: _____