SCS CPAP Services

#9 Fifth Avenue North • Yorkton • SK • S3N 0Y9

PRE-DIAGNOSIS HOME SLEEP TEST REQUEST

☑ Home Sleep Test for OSA
☑ Auto CPAP Titration – when intitial Home Sleep Test indicates AHI of 10 or greater

Patient Information:

NAME: _____ HEIGHT: _____
HSN: _____ WEIGHT: _____
DOB: _____
SEX: M ____ F ____

PHONE NUMBER: _____

☑ Please Refer to Sleep Specialist or Respirologist for Evaluation if Test Indicates Positive Result

Physician Name: _____ Date: _____

Physician Signature: _____

PHYSICIAN PLEASE FAX REQUEST TO SASKATOON OR YORKTON OFFICE
TESTING COMPLETED BY APPOINTMENT ONLY