



# Medigas®

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## Level 3 Home Sleep Study Request

Date: \_\_\_\_\_

**Patient Name** (please print): \_\_\_\_\_  
(First Name) (Last Name)

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)  
\_\_\_\_\_ (Cellular)

Date of Birth: \_\_\_\_\_ P.H.I.N: \_\_\_\_\_

**Reason for Request (check all which apply):**

- Snoring
- Stop Breathing
- Sleepy during the day

**Pertinent Medical History (check all which apply):**

Body Mass Index \_\_\_\_\_ (if? please give height \_\_\_\_\_ cm, and weight \_\_\_\_\_ kg)

Hypertension

Cardiovascular Disease

Significant Illness  Please Note: \_\_\_\_\_

(eg. congestive heart failure, MI, stroke, diabetes, hyper/hypothyroid)

**Current Medications:**

\_\_\_\_\_  
\_\_\_\_\_

**Referring Physician (please print):**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_