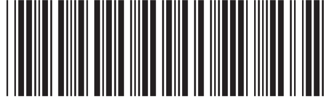
773- SDC-16/06-04-15 (Web)



Instruct

BOZEMAN HEALTH
DEACONESS HOSPITAL

Patient Label

Name: ___________________________

DOB: ______________________________

M#:_______________________________

Plan of Care

Sleep Study Discharge Instructions

Patient's name:

Please schedule a follow-up appointment with your primary care physician ________________________________ to discuss the results of your sleep study done on ____________.

Please allow 14 days for your physician to receive the results of your sleep study.

Patient's signature ____________________________________

Date ______________________ Time _____________________

Tech signature ____