



**TRANSCEND
MEDICAL**
Going Beyond The Limits

800-403-3740

Fax: 256-259-1498

Fax Cover Sheet

Date: _____

From: _____

Attention: _____

Fax: _____

Phone: _____

of Pages Including Cover Sheet _____

OVERNIGHT TEST RESULTS

FOR: _____

Date of Birth _____

☐

The SpO2 was under 5 minutes—may want to retest in 6 months or less if condition worsens

☐

SpO2 less than 88% for over ____ hr. ____ minutes—We have included a script to complete—if you feel patient will benefit for nocturnal O2
(Please send office notes—mentioning need for O2)

☐

This test was done while using _____
the SpO2 less than 88% for over _____ hr. _____ minutes

☐

Other _____

Please Return Information Requested to Fax 256-259-1498. THANK YOU FOR YOUR SUPPORT This documentation accompanying this transmission may contain confidential health information that is highly privileged. This information is intended for the use of the _____ Individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by the law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this documentation is strictly prohibited If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of this documentation.