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 _____