PROVIDER NAME: **PHONE:**

RUSleeping™ *RTS*

Patient Name: _____   Date: _____

Address: _____   Phone: _____

City: _____   State: _____   Zip: _____

Date of use: ☐

Total number of events: ☐

AH index *(Average events/hour)*: ☐

HR 1	Is ERR displayed?	Yes ☐	No ☐
HR 2	Is ERR displayed?	Yes ☐	No ☐
HR 3	Is ERR displayed?	Yes ☐	No ☐
HR 4	Is ERR displayed?	Yes ☐	No ☐
HR 5	Is ERR displayed?	Yes ☐	No ☐
HR 6	Is ERR displayed?	Yes ☐	No ☐
HR 7	Is ERR displayed?	Yes ☐	No ☐
HR 8	Is ERR displayed?	Yes ☐	No ☐
HR 9	Is ERR displayed?	Yes ☐	No ☐

Subject ID: S/N Code:
Comments:

RESPIRONICS