Stages of Sleep Chart

Patient's Name:

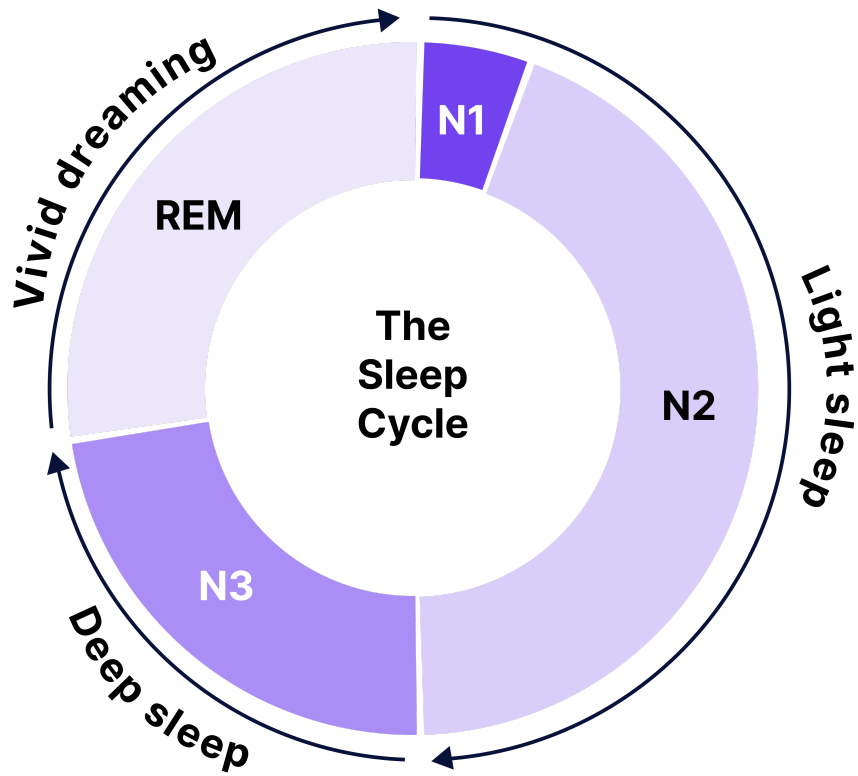**Date of Birth:**

Gender:

Medical History (if needed):

Notes:

Referring Physician: