NOCTURNAL OXYGEN SATURATION LOG

Month/Year: _____
Patient Name: _____
Device Type: _____
Target SpO2 Range: _____
Prescribed O2 Flow (LPM): _____

DATE	BEDTIME	WAKE TIME	AVG SPO2 (%)	LOW SPO2 (%)	OBSERVATIONS / SYMPTOMS

Provider Notes / Instructions:
This document is for personal tracking purposes only. Consult a medical professional for clinical diagnosis.