

**McLaren Print System Order**

**Order No: 47272**  
**Order Date: 2019-07-30**  
**User: Andrea Bennett**  
**Phone: 342-3900**

**Ship Location: McLaren Flint Beechill Ctr**  
**G3200 Beecher Rd**  
**Flint, MI 48532**

**Forms**

**Quantity: 500**  
**Paragon Dept No: 36110**  
**Dept Name: Sleep Center**  
**Company Number: 60**

**Order Total Price: 0.00**

**Item Number: 17555**  
**Item Description: Education and Treatment Consent**  
**Revision Date: 6/2014**  
**Print: 1 sided black and white**  
**Paper: 20# White Text**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish:**  
**Drill: None**  
**Misc Info:**

McLaren Flint  
Sleep Diagnostic Center  
**EDUCATION AND TREATMENT CONSENT**

- I have been informed that I need to schedule a follow-up appointment with the physician who ordered this test to discuss test results.
- Sleep Apnea and the benefits of treatment as well as the consequences of not initiating treatment have been explained.
- I understand that the consequences of not being treated for a breathing disorder during sleep can include excessive sleepiness, headaches, personality disorders, poor judgement, increases in blood pressure, stroke, heart attack and even death.
- I understand that I am to avoid high-risk activities if excessive daytime sleepiness persists. In general, I should avoid situations whereby I can hurt myself or others should I fall asleep unexpectedly.
- I understand that I **should not drive while sleepy** and if sleepiness occurs while driving, I should pull off the road to a safe place as soon as possible.

**The following treatment was recommended:**

- CPAP titration as scheduled unless contacted for cancellation by the Sleep Center  
Date: \_\_\_\_\_ Time: \_\_\_\_\_ PM
- Oxygen @ \_\_\_\_\_ liter per minute during sleep
- Continuous Positive Airway Pressure (CPAP) @ \_\_\_\_\_ on H2O
- Bi-level Positive Airway Pressure @ \_\_\_\_\_ IPAP \_\_\_\_\_ EPAP on H2O during sleep

**Regarding the Recommendation for Home CPAP, Bi-level or Supplemental Oxygen:**

- I have voluntarily agreed to begin this treatment and will contact the Sleep Center if I am not contacted by my CPAP supplier within seven days.
- I have voluntarily delayed treatment until I speak with my Physician.
- I have voluntarily refused treatment at this time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Spec Info:**

\_\_\_\_\_  
Patient Signature                      Date                      Technologist                      Date

EDUCATION AND  
TREATMENT CONSENT  
17555.014



8206

Form with fields for patient information, likely a name and address, with a header 'EDUCATION AND TREATMENT CONSENT'.