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)@_____ cm H2O

_____ Bilevel Positive Airway Pressure @ _____IPAP _____EPAP cm 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. **

PATIENT: _____ Date: _____

_____ _____
Patient Signature Date Technologist Date

PT.

MR.#/RM.

DR.