McLaren Business Products

McLaren Print System Order

Order No: 6431
Order Date: 2014-10-13
User: Janice Ashley
Phone: 810-342-3900

Ship Location: SLEEP CENTER/ JANICE ASHLEY
g-3200 Beecher Rd Suite ZZZ
Flint, MI 48532
Forms
Quantity: 100
Paragon Dept No: 36110
Dept Name: SLEEP DIAGNOSTIC CENTER
Company Number: 60

Order Total Price: 0.00

Item Number: 17555
Item Description: Education and Treatment Consent
Revision Date:
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) @ _____ 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

EDUCATION AND TREATMENT CONSENT

8206