**McLaren Sleep Diagnostic Center**
**Clarkston, Michigan**
**(248) 922-6840**

# EDUCATION AND TREATMENT ACCEPTANCE

____ I have been informed that I need to schedule a follow-up appointment with the physician who ordered this study.

____ I viewed a DVD on Obstructive Sleep Apnea and CPAP 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:________________P M

_______ **Follow up with your physician to discuss a treatment plan**

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

The following mask appeared to work best during the study: ____________________________________

The following mask(s) was tried without success: ______________________________________________

**The interpreting physician will determine your optimal treatment settings and they Will be included in the report to your physician.**

PATIENT:__________________________________________ Date: ______________________

_____________________________________________ _____________________________________________

patient signature date witnessed date

**EDUCATION AND TREATMENT ACCEPTANCE**

MO-17555 (9/14)

PT.

MR.#/RM.

DR.