Consent for Treatment

A polysomnogram is a sleep study which records detailed information while you sleep. A technician will attach sensors to monitor your:

- brain waves
- Heart rate
- Breathing rate
- Oxygen level
- Eye movements
- Chin movement

The sleep center will use this information to prepare a detailed report about your sleep. The doctor who sent you to the sleep center will receive a copy of this report. He or she will discuss the results with you.

Risks

There is no major health risk involved with this sleep study.

Agreement

My signature below indicates that I understand and agree with the following statements:

1. The sleep study may not detect the cause of my sleep problem,
2. A technician will attach sensors to my body for the study.
3. The sensors may smell bad when they are placed on me.
4. The removal of the sensors may cause redness of my skin.
5. A video camera will record me as I sleep. A technician will watch me on a monitor in the control room to ensure my comfort and safety.
6. I will be free to roll over and move in bed during the study.
7. I will ask for help if I need to get out of bed for any reason.
8. The technician may need to enter the room to wake me for technical reasons.
9. The study may show that I stop breathing many times during the night. If this happens, a technician may enter my room to give me a treatment device to try. This treatment is called positive airway pressure, or PAP. To use this treatment, I will wear a mask that covers either my nose or my nose and mouth.
10. I understand why I am taking this sleep study.
11. The sleep center staff explained this procedure to me. I understand what is going to happen during the study.

I _____consent to the procedure and medical treatment for myself or for the patient, whom I am either the parent of or authorized legal representative.

_____ _____

Signature of Patient Date

_____ _____

Signature of Legally Authorized Representative Date