NW REST

Sleep Study Consent Form

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Please review and initial each of the following statements:

_____ My physician has informed me that I need a comprehensive sleep study performed

_____ I understand that the type of sleep study being performed is: _____

_____ I understand that untreated sleep disorders can increase the risk of stroke and heart attack, and that sleep studies are performed to diagnose the presence and severity of these disorders in order to develop an appropriate treatment plan.

_____ I understand that sensors will be attached to my scalp, face, chest, abdomen, fingertip and legs. I will be continuously monitored by a licensed and trained Polysomnographer via computer software and infrared video.

_____ I understand and consent to video and audio recording during my sleep study. These recordings are used for physician interpretation of sleep-related events and to ensure the safety and security of all patients and staff. All recordings are confidential and handled in accordance with HIPAA regulations.

_____ I understand that I may be awakened to be connected to a Positive Airway Pressure Device. If so, the rest of the night is spent adjusting to the positive pressure to eliminate snoring, apneas, or shallow breathing episodes.

_____ I understand that the possible side effects of positive pressure devices can include dry air passages, skin irritation, earache, air swallowing and bloating and that these may be of short duration.

_____ I understand that a $250 fee will be assessed for all appointments not canceled without a 48-hour notice or for no-showing for your scheduled test.

My signature below is to certify that I, the undersigned, hereby consent to and authorize the administration of all procedures and/or treatments of sleep diagnostics.

_____

Patient Name Date of Birth

_____

Patient Signature Date