

McLaren Print System Order

Order No: 41984
Order Date: 2019-01-16
User: Andrea Bennett
Phone: 342-3900

Ship Location: McLaren Flint Beechill Ctr
G3200 Beecher Rd
Flint, MI 48532

Forms

Quantity: 500
Paragon Dept No: 36110
Dept Name: Sleep Center
Company Number: 60

Order Total Price: 0.00

Item Number: 17555
Item Description: Education and Treatment Consent
Revision Date: 6/2014
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) @ \_\_\_\_\_ on H2O
Bilevel Positive Airway Pressure @ \_\_\_\_\_ IPAP \_\_\_\_\_ EPAP on 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spec Info:

\_\_\_\_\_  
Patient Signature Date Technologist Date

EDUCATION AND TREATMENT CONSENT



8206

Form with fields for patient information