McLaren Business Products

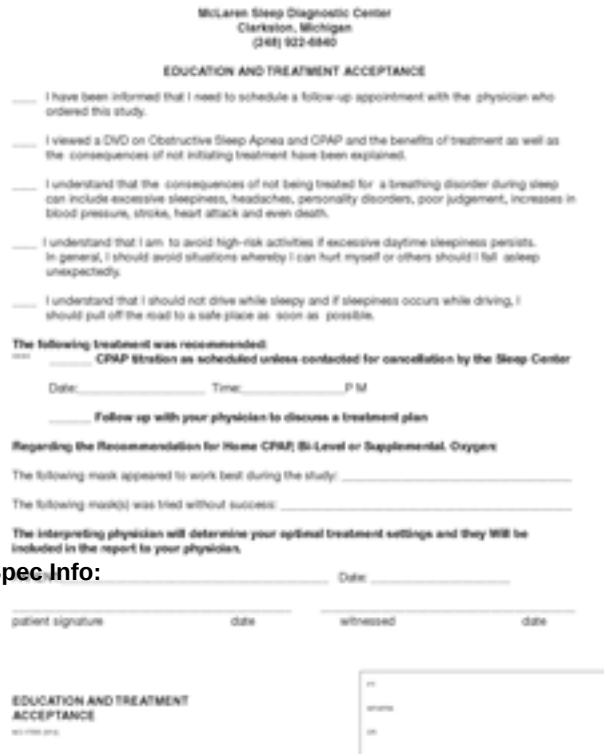
McLaren Print System Order

Order No: 52679
Order Date: 2020-02-18
User: Bill Bader
Phone: 2489226840

Ship Location: McLaren Clarkston Sleep Center, Suite 355
5701 Bow Pointe Dr Suite 355
Clarkston, MI 48346
Forms
Quantity: 500
Paragon Dept No: 8300
Dept Name: Sleep Diagnostic Center
Company Number: 310

Order Total Price: 0.00

Item Number: MO-17555
Item Description: Education and Treatment Acceptance
Revision Date: 9/2014
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:



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.

_____ Date: _____

patient signature date witnessed date

EDUCATION AND TREATMENT ACCEPTANCE

Spec Info: