Name: _____

DOB: _____

BON SECOURS SLEEP DISORDERS CENTER
Bon Secours Richmond Health System

Consent for Sleep Study

I _____ authorize Dr. _____
and/or such assistants at may be selected by him/her, to perform the following procedure:
Polysomnography Study (Sleep Study, Multiple Sleep Latency Test, Maintenance of Wakefulness Study)

Details

A sleep study, or polysomnogram, is a test that records detailed information about how your body acts while you sleep. This test is most often performed overnight, but may, under certain situations, be performed during the daytime. A technician will attach sensors to your body for the study. The sensors will keep track of these body functions:

- Brain wave activity
- Breathing rate
- Eye movements
- Heart rate and rhythm
- Blood oxygen level
- Leg movements
- Snoring
- Jaw or chin movements

The study may also involve other sensors. The sensors send signals to a computer, which records data while you sleep. You also will have two elastic bands placed on your abdomen and chest to monitor respiratory movement, a sensor on your finger to monitor oxygen saturation and a small sensor under your nose to monitor airflow.

Six hours of recording is necessary for a complete study. The sleep center will use the information from your study to prepare a detailed report about your sleep. The doctor who sent you to the sleep center will receive a copy of this report.

Risks

There are no major health risks involved with this sleep study. Injury could result if you attempt to disconnect the sensors and electrodes yourself. If a Continuous Positive Airway Pressure (CPAP) device is used during your study, it may cause discomfort, bloating, nasal irritation, contact dermatitis or dryness.

Alternatives

A sleep study is the most accurate means of identifying sleep-related breathing disorders at this time. I understand that following this diagnostic procedure my physician may recommend further tests or treatment options.

Agreement

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

1. This 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 removal of the sensors may irritate my skin or cause redness.
4. The technician may be of the opposite sex and I agree to continue with the test in this circumstance.
5. I will be free to roll over and move in bed during the study.
6. I will need to ask for help if I must get out of bed for any reason.
7. The technician may need to enter the room to wake me if there is a problem.
8. 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 treatment. 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.
9. If I leave the center before the completion of the study, I may be billed for the entire study.
10. I have disclosed all current medications, including over-the-counter medications.
11. I understand why I am having this sleep study.
12. The sleep center staff explained this sleep study to me. I understand what is going to happen during the study.
13. All of my questions have been answered to my satisfaction.

Photography/Video recording

As part of the sleep study it is necessary for clinical purposes to videotape you while you sleep. Any photographs or video recordings obtained during the course of the sleep study will remain confidential, and will be considered a protected portion of your medical record. By signing below, you agree that personnel related to your care will have access to such photographic or video recordings.

_____ _____
Signature (Patient or Guardian) Date

_____ _____
Signature (Witness to signature) Date