Pulmonary and Sleep Associates of Marin

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Consent for Sleep Study and Permission to Record Audio and Video

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

The study may also involve other sensors. The sensors send signals to a computer. 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 then 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:

- This sleep study may not detect the cause of my sleep problem.
- A technologist will attach sensors to my body for the study.
- The removal of the sensors in the morning may irritate my skin and cause redness.
- An audio and video camera will record me as I sleep. I understand that such recordings will be used for clinical purposes, to assist in evaluating my sleep. A technician will watch me on a monitor in the control room.
- I will be free to roll over and move in bed during the study.
- I will call the technologist via intercom if I must get out of bed for any reason.
- The technician may need to enter the room to wake me if there is a problem.
- 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.
- I understand why I am taking this sleep study.
- The sleep center staff explained this sleep study to me. I understand what is going to happen

during the study.

Privacy

Any recordings obtained during the course of the sleep study will remain confidential, and will be considered a protected portion of my medical record. I understand my privacy rights and agree to proceed with my sleep study.

Patient Name: _____

Patient Signature: _____

Date: _____

Or Legal Guardian/representative:

Name: _____

Signature: _____

Date: _____