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**Informed Consent**

* My physician has informed me that I need a sleep study performed, in the interest of my health and proper medical care.
* My physician has explained the sleep study to me and the benefits and risks of having the test performed, as well as the risks of leaving sleep disorders untreated.
* My physician has explained to me that I may need PAP (positive airway pressure) therapy during the sleep study, if applicable.
* I understand that if I terminate the sleep study early I will be required to sign a waiver.
* I understand that if I take a sleeping aid I must inform my technician.
* I understand that the sleep study will be videoed. This is for the safety of myself and others, as well as to assist in diagnosis.
* I have had the opportunity to ask questions, and I consent to the sleep study.

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AM/PM

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Attending Technician/Technologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Technician/Technologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_