



## ***THE KAZMIR CENTER FOR SLEEP DISORDERS***

### ***CONSENT FOR TREATMENT***

I, \_\_\_\_\_, am a patient of the Kazmir Center for Sleep Disorders at Saint Barnabas Medical Center.

I understand that I will be video and/or audio taped in conjunction with the study being performed and authorize the use of video equipment for scientific and educational purposes only. The video may be used by the Kazmir Center for Sleep Disorders provided my identity is not revealed.

I have reviewed the video on "Visiting the Sleep Lab Sleep Apnea Diagnosis & Treatment". I hereby acknowledge that CPAP has several possible side effects that could develop during the course of the treatment. Some possible side effects are:

1. Nasal obstruction may be produced by dryness of the nose and /or allergies. The doctors have explained to me that this is no a common occurrence and that I may be treated with nasal drops or sprays.
2. In the initial part of CPAP treatment, some patients may develop difficulty falling asleep until patient gets used to the machine. This may require additional temporary treatment with sedatives.
3. There is a possibility that I could develop a condition called Pneumothorax. This is a collapse of one of the lungs, perhaps related to the pressure used in the CPAP treatment. The doctors have explained that no one has had this problem in the history of the use of this treatment and that this is probably because the pressures used are relatively low.
4. Some patients develop a "buzzing" or dullness sensation in one or both ears that will disappear soon after waking up.

The doctors have explained that I may need periodic testing based on my symptoms.

I understand that these are the most common problems. However, I should promptly inform the Kazmir Center for Sleep Disorders if there are any unexpected changes in my condition.

I understand that I have not been compelled or forced to elect this treatment and that I may decide to stop using the CPAP device at any time during the night.

I also understand that if I decide to discontinue the treatment, I must inform my doctor in this Center prior to doing so. In this way, my doctor can offer me other alternatives for treatment.

On this basis, I authorize this Center to start the treatment with CPAP and follow me as it is deemed advisable.

I have been advised by the physicians and staff of The Kazmir Center for Sleep Disorders not to drive to and from the hospital if I am drowsy or if I am scheduled for the Multiple Sleep Latency Test (MSLT).

**I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND AND CONSENT TO THE ABOVE PROCEDURE (S), AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. I CERTIFY THAT ALL BLANKS AND STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.**

\_\_\_\_\_  
(SIGNATURE OF PATIENT)

\_\_\_\_\_  
(WITNESS TO SIGNATURE)

\_\_\_\_\_  
(WHEN PATIENT IS A MINOR, SIGNATURE OF PERSON AUTHORIZED TO CONSENT FOR PATIENT)

\_\_\_\_\_  
(RELATIONSHIP TO PATIENT)