SLEEP TEST CONSENT FORM

BIRON SOINS DU SOMMEIL hereafter « BSS »

Last Name:_____ **First Name:**_____ **Order #:** _____

Date of birth: _____ **Test date:** _____
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PURPOSE OF THE TEST

The purpose of the test is to obtain data on the quality of your sleep and determine whether you suffer from a sleep disorder (for example: sleep apnea or insomnia) and/or to calibrate a continuous positive airway pressure (PAP) therapy.

PRESCRIBED TEST *(to be filled by a BSS representative)*

In-lab sleep tests

- ☐ Polysomnography (PSG)
- ☐ Split-night study – PSG with CPAP titration according to protocol
- ☐ Pediatric polysomnography (PSG)
- ☐ Manual PAP titration
- ☐ Multiple sleep latency test (MSLT)
- ☐ Maintenance of wakefulness test (MWT)

At home tests

- ☐ Pediatric nocturnal saturometry
- ☐ Nocturnal saturometry under therapy
- ☐ Sleep cardiorespiratory polygraphy (PCR)
- ☐ Automated PAP titration

☐ Case management protocol *(to be filled by a BSS representative)*

Protocol allowing to rapidly initiate a CPAP therapy start-up test, if deemed necessary following the completion of the prescribed test and according to the respirologist's recommandations. The case management protocol provides for an in-person consultation with the respirologist if needed.

Any patient is free to withdraw from this protocol at any time and at his/her sole discretion.

A clinical questionnaire has to be filled before a diagnostic test, except if the test is repeated.

INCONVENIENCES

- Polysomnography: sleep recording poses no risk other than a possible temporary skin irritation in the area where the sensors or mask have been positioned.
- PAP titration: abdominal bloating can sometimes occur as a result of the PAP. A healthcare professional will be available to control or minimize the side effects in the case of an overnight sleep laboratory study.
- Pediatric nocturnal oxymetry: in order to avoid accidental choking during this test, the oxygen sensor will be placed on your child's toe.

BSS representative's initials:_____ Patient's initials: _____

Biron

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FOR ALL BILLED SERVICES: RESPIROLOGIST'S NOTICE OF NON-PARTICIPATION

To insured persons under health insurance plan

I notify you that I am a professional non-participating in the Health Insurance Plan. As such, I may not claim payment of my fees from the Régie de l'assurance maladie du Québec. If you have recourse to my professional services, you must therefore pay me directly the cost of insured services I will dispense to you. You may neither demand or obtain from the Régie de l'assurance maladie du Québec the reimbursement of the cost of insured services which you will have paid to me. This notice is given to you in accordance with the Health Insurance Act (chapter A-29) and the regulations.

Name of non-participating professional : the respirologist will be duly identified on the sleep test report.

BIRON SOINS DU SOMMEIL'S COMMITMENT

The Biron Soins du sommeil team is committed to providing you with high quality technology and health professionals trained in sleep medicine. This guarantee of quality is added to all our protocols written in accordance with the Canadian and American recommendations of sleep medicine. The interpretation of your test and clinical questionnaire will be done by a self-employed respirologist and a member of the Collège des médecins du Québec.

PATIENT'S RESPONSIBILITY

I hereby acknowledge my understanding that the clinical data will be derived from a self-administered clinical questionnaire and that the interpreting respirologist will not necessarily have met with me beforehand. The respirologist's recommandations will therefore be provided for information purposes only and will have to be validated and discussed with the requesting physician.

In the event that the data collected during the prescribed test may not be interpreted for any reason and that a study report could not be issued, the prescribed test will be repeated at Biron Soins du sommeil's cost. A period of six (6) months will be allocated to me to benefit from such test free of charge. In the case that a test has to be repeated, this consent form will remain valid for the next six (6) months. However, if I refuse to complete the prescribed test by, for example, leaving Biron Soins du sommeil's premises before its completion or if I refuse to repeat the prescribed test, I understand that no refund will be issued by Biron Soins du sommeil.

PATIENT'S CONSENT

I received and understand the purpose, the possible inconveniences of the test, the notice of non-participation of the respirologist and the respective responsibility of each party. According to the service received, I had the opportunity to ask any questions that I feel are relevant to the different aspects of the test and I received satisfactory answers. I understand that additional fees may apply if additional tests were required to establish a diagnosis or initiate CPAP treatment. I am aware and accept that I will be filmed as part of a sleep laboratory diagnostic test, if applicable.

I voluntarily and freely agree to participate in the prescribed examination.

Patient's signature[1]_____ Date:_____

BSS representative's signature _____ Date:_____

[1]parent's name (children less than 14 years) or legal representative in case of incapacity