WellSleep

UNIVERSITY OF OTAGO, WELLINGTON SLEEP INVESTIGATION CENTRE
Bowen Hospital | Churchill Drive | Crofton Downs | Wellington
Tel 04 920 8819 | Fax 04 920 8861 | Email wellsleep@otago.ac.nz

CONSENT FORM

IMPORTANT!

Please deliver, post, fax or email this form before your admission together with the Health Questionnaire to:

WellSleep
c/- Bowen Hospital
98 Churchill Drive
Crofton Downs
Wellington 6035 (stamped self addressed envelope provided)

Fax: (04) 9208861
Email: wellsleep@otago.ac.nz

If this is not possible please make sure you bring the forms with you when you arrive for admission, if you faxed or emailed the forms to us, please bring the originals with you

Admission Day: M T W T F S S (Circle one) Admission date:
Admission Time:

Personal Details (patient to complete and return before study) PLEASE RETURN URGENTLY			
Name			
Mr/Ms/Mrs/Miss/Dr			
	Surname	Given Names	
Preferred name		Age	
Date of Birth		NHI no.	
Address			
Telephone	hm	wk	mob
Email			

Procedure (Specialist to complete)			
Procedure			
Approximate length of stay	hours	nights	
Admitting Specialist			

Request and consent to Sleep Study procedures

I (patient or guardian) agree that I have had an explanation to my satisfaction of the intent, risks and likely outcomes of the procedure I am receiving. YES / NO
I am aware that I may ask for more information about treatment at any time. YES / NO
I accept the advice of my specialist and ask that the above procedure is carried out. YES / NO
I agree to allow the use of my physiological sleep study data for future WellSleep research YES / NO

Patient/Guardian
Signature Date:
Admitting Specialist
Signature Date:

Advance Directive **(Patient to complete if required)**

Please circle appropriate and provide a copy
Living Will/Advance Directive Enduring Power of Attorney Do Not Resuscitate Order