UNIVERSITY of OTAGO
Te Whare Wānanga o Otāgo
NEW ZEALAND
WELLINGTON

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 procedure together with the Health Questionnaire form 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 have completed the forms prior to study staff arrival, if you faxed or emailed the forms to us, please have the originals with you on the night of study

Procedure Day: M T W T F S Sun (Circle one) Procedure date:

Procedure 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			
Phone Number(s)	H	W	Mob
Family Doctor name and practice:			
Procedure (Specialist to complete)			
Diagnosis			
Procedure			
Referring 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:

Referring Specialist
Signature Date: