



INFORMED CONSENT FOR THE TREATMENT OF

OBSTRUCTIVE SLEEP APNEA and SLEEP

DISORDERED BREATHING

Obstructive sleep apnea (OSA) is a medical condition with a dental treatment. For OSA to be treated by a dentist, a diagnosis of OSA must be made by a physician trained in the field of Sleep Medicine. If you have not been diagnosed with OSA by your physician, please understand that we will not proceed with treatment without an overnight sleep study in a sleep lab and a diagnosis of OSA by the attending sleep physician. We will work in collaboration with your physician to achieve the best results possible for the treatment of your sleep apnea.

SUCCESSFUL TREATMENT: Oral appliance therapy is a very effective treatment. However, no therapy works 100% of the time. The mandibular advancement device (MAD) works by moving the jaw and tongue forward at night which acts to keep the airway open. As with any medical therapy, successful treatment of OSA using dental appliances cannot be guaranteed. Success depends on many things. The most important component of success is patient compliance. By signing this document, you hereby agree to follow our instructions in detail. Failure to do so may result in a poor clinical outcome.

COMPLICATIONS OF TREATMENT: OSA is an unusual disease because it has been associated with many co-morbid medical conditions. As a result of OSA, or as a complication of OSA treatment, patients may develop any or all of the following temporary or permanent co-morbid diseases: coronary artery disease; high blood pressure; diabetes; cerebrovascular disease; stroke; heart problems; heart attack; atrial fibrillation, depression, mood disorders, sexual dysfunction, weight gain, obesity; excessive daytime sleepiness; increased work related and traffic related accidents; and death.

Dental Issues: A number of temporary or permanent dental issues can develop as a result of long term treatment of OSA with a mandibular advancement device (MAD), including but not limited to: jaw joint pain; moderate or severe TMJ dysfunction; headaches; backaches; neck aches; pain on chewing; facial pain; popping and noise in the jaw; sore teeth; dental decay, gum (periodontal) disease, gingivitis; worsening of periodontal pockets; tooth loss; loosening of teeth, dry mouth or excess saliva; fracturing or loosening of dental fillings, crowns or bridges; short term or long term bite changes; spacing or shifting of teeth; tilting of teeth; profile changes; lessening of overbite or over jet; dental infection; infection of the gums; difficulty chewing; oral cysts, oral tumors, oral cancer, and death.

You should be aware that complications as a result of oral appliance therapy have been minor; however, it is the patient's responsibility to immediately inform our office of any issues which may develop to prevent a permanent condition or complication.

Initial_____



FINAL SLEEP STUDY AND EVALUATION: After your appliance is placed, it will be adjusted by us to achieve the best results possible. When your apnea symptoms have improved and we are satisfied with the results of the adjustments, you will be referred back to your physician for post-treatment evaluation and a post-treatment sleep study. This evaluation is to insure that your apnea is adequately controlled by the MAD and that no further adjustments or other treatment is needed. Your treatment must be confirmed by an in-lab sleep study and evaluated by your physician after we complete our adjustments.

Follow-up appointments are required with our office on a 6 month or yearly basis to check the effectiveness of your appliance and the success of your OSA treatment. Failure to maintain these follow-up appointments will constitute a lack of compliance with our office's treatment plan. Any decision on your part to forego follow-up appointments places your health at risk and increases the probability of complications and treatment failure.

Additionally, recall appointments should be kept with your general dentist on a three month schedule for the first year that you wear a MAD to evaluate your dental hygiene, gums and check for decay. By signing this agreement you agree to schedule the recommended recall appointments and to use prescription oral topical fluoride daily for the prevention of decay and periodontal disease. The prescription fluoride is to be used for as long as you wear a MAD.

ALTERNATIVE TREATMENTS: By signing this consent form you acknowledge that you have been made aware of reasonable alternatives to MAD therapy for obstructive sleep apnea including, but not limited to: tracheotomy; CPAP; oral or pharyngeal surgery; positional sleep therapy; weight loss and exercise. Additionally, you are aware that more than one treatment may be necessary for the best results.

WHEREFORE: I give my consent for the treatment of my OSA using a mandibular advancement device (MAD). I agree and consent to allow qualified members of this office to examine my mouth, teeth, jaws, gums, and associated structures. I give consent for the taking of x-rays, photos, impressions and any other procedures necessary for the treatment of my OSA. I, also, give consent for a home sleep study, if necessary, for the adjustment of my appliance. I consent for the contents of my record to be shared with my physician and insurance company.

I affirm that I have read this document and have been given adequate information regarding the treatment of my condition to give my informed consent. I understand the proposed treatment of my OSA using MAD therapy and I have been given the opportunity to ask questions. All my questions have been answered and I am ready to proceed with treatment.

Patient Signature: _____ DATE: _____

Print Name: _____

WITNESS: _____ DATE: _____