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REQUEST FOR AN ORAL DEVICE THERAPY

To the patient: you have decided to proceed with the fabrication of an oral appliance to aid in the treatment of your obstructive sleep apnea and snoring. You have discussed the alternatives of care with your sleep physician. Oral appliance therapy attempts to open the collapsed airway by holding your tongue forward. When compared to CPAP, they are 42% successful in unselected patients. They are more successful in cases of mild sleep apnea and much less in severe sleep apnea. Weight gain may make the oral device ineffective.

I understand that there are multiple treatments for obstructive sleep apnea including, but not limited to, CPAP, BiPAP, throat surgery, facial surgery as well as oral appliances. It is generally agreed, by the medical community, that the most effective treatment, when used properly, is Positive Airway Pressure (PAP). All treatments rely on patient compliance with the instructions given by the physician, dentist or their auxiliaries.

I am aware that oral appliances have many possible side effects, some of which may not become evident for two to four years. Oral appliances can loosen ill fitting crowns and fillings, loosen teeth, irritate gums and soft tissue, cause tooth or muscle aches, move teeth, cause or worsen temporomandibular joint problems, increase salivation short term and become ill fitting if significant dental work is done. Most problematic is if, once removed in the morning, you have difficulty closing your back teeth normally. With long term use, as many as 80% patients will have permanent advancement of their mandible or permanent tooth movement. Patients who have had adult orthodontics can always expect tooth movement. For a small percentage of patients using an oral appliance the number of apneic and hypopneic events can increase and a post placement polysomnogram (sleep study) is recommended. Pregnant women should consider discontinuing use of their appliance and returning to CPAP during pregnancy for the health of the baby.

I am also aware that other unexpected risks or complications, not discussed, may occur and no guarantees or promises have been made to me concerning the results of this treatment. The potential benefits and risks of an oral appliance use have been discussed with me and I request such an appliance be fabricated for me. I am also aware that there is no guarantee the oral device will be effective in my particular case.

I also understand that there is no guarantee that my medical insurance will cover the costs of such a device and that I, the patient, am fully responsible for any fees involved.

I also am aware that failure to treat severe obstructive sleep apnea can result in a higher risk of hypertension, angina, and death from stroke, myocardial infarct and cardiac arrhythmia. Any level of sleep apnea can result in overwhelming tiredness.

I have read this form and have discussed it with the dentist, and I understand what is said.
I have received a copy of this form.

Oral Appliance:_____Fee:_$___ Insurance company authorization #:_____
If the fee is paid in full, it will include all necessary follow-up visits for the first six months

X_____ X_____
Patient Date signed by patient

I have explained the above statement to the patient and answered all questions.

X_____ X_____
Dentist Date signed by dentist