

Informed Consent for the Treatment of Sleep Disordered Breathing

You have been diagnosed as requiring treatment for sleep-disordered breathing (snoring and/or obstructive sleep apnea). This condition may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels, which in turn, may result in the following: excessive daytime sleepiness, irregular heartbeats, high blood pressure, heart attack or stroke.

What Is Oral Appliance Therapy?

Oral appliance therapy for snoring/obstructive sleep apnea attempts to assist breathing during sleep by keeping the tongue and jaw in a forward position during sleeping hours. Oral appliance therapy has effectively treated many patients. However, there are no guarantees this therapy will be successful for every individual. Every reasonable effort will be made to ensure the success of your treatment. However, you are responsible for the fees regardless of the efficacy of treatment. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time you may still experience the symptoms related to your sleep disordered breathing. A post-adjustment polysomnogram (sleep study) is necessary to objectively assure effective treatment. We will administer this test as part of your treatment.

Side Effects and Complications of Oral Appliance Therapy

Published studies show that short-term side effects of oral appliance use may include excessive salivation, difficulty swallowing (with appliance in place), sore jaws, sore teeth, jaw joint pain, dry mouth gum pain, loosening of teeth and short term bite changes (how upper and lower teeth come together). There are also reports of dislodgement of ill-fitting dental restorations. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance. Long-term complications include bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once appliance therapy is discontinued. If not, restorative treatment or orthodontic intervention may be required for which you will be responsible.

Treatment fees include all visits incurred during the first 12 months of treatment.

Follow up visits with the provider of your oral appliance are mandatory to ensure proper fit and allow an examination of your mouth to assure a healthy condition. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended you cease using the appliance until you are evaluated further. Good communication is essential for the best treatment results.

Alternative Treatments for Sleep Disordered Breathing

Other accepted treatments for sleep-disordered breathing include behavioral modification, CPAP (positive airway pressure) and various surgeries. It is your decision to have chosen oral appliance therapy to treat your sleep disordered breathing and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this provider's office. Failure to treat sleep disordered breathing may increase the likelihood of significant medical complications.

I certify that I have read, or had read to me, the contents of this form and that I understand the explanation of the proposed treatment. I have asked and had answered any questions I may have about this form or the proposed treatment. I realize and accept any risks and limitations involved, and do consent to oral appliance therapy to treat my sleep disordered breathing.

Date: _____

Signed: _____ Witness: _____

List any medications which have caused an allergic reaction:

- Y N Antibiotics
 Y N Aspirin
 Y N Barbiturates
 Y N Codeine
 Y N Iodine
 Y N Latex
 Y N Local anesthetics

- Y N Metals
 Y N Penicillin
 Y N Plastic
 Y N Sedatives
 Y N Sleeping pills
 Y N Sulfa drugs

Other allergens:

List any medications you are currently taking:

- Y N Antacids
 Y N Antibiotics
 Y N Anticoagulants
 Y N Antidepressants
 Y N Anti-inflammatory drugs
 (non-steroid)
 Y N Barbiturates
 Y N Blood thinners

- Y N Codeine
 Y N Cortisone
 Y N Diet pills
 Y N Heart medication
 Y N High blood pressure medication
 Y N Insulin
 Y N Muscle relaxants
 Y N Nerve pills

- Y N Pain medication
 Y N Sleeping pills
 Y N Sulfa drugs
 Y N Tranquilizers

Other current medications:

Medical History

- Y N Anemia
 Y N Arteriosclerosis
 Y N Asthma
 Y N Autoimmune disorders
 Y N Bleeding easily
 Y N Chronic sinus problems
 Y N Chronic fatigue
 Y N Congestive heart failure
 Y N Current pregnancy
 Y N Diabetes
 Y N Difficulty concentrating
 Y N Dizziness
 Y N Emphysema
 Y N Epilepsy
 Y N Fibromyalgia
 Y N Frequent sore throats
 Y N Gastroesophageal Reflux
 Disease (GERD)
 Y N Hay fever
 Y N Heart disorder
 Y N Heart murmur
 Y N Heart pounding or beating
 irregularly during the night

- Y N Heart pacemaker
 Y N Heart valve replacement
 Y N Heartburn or a sour taste
 in the mouth at night
 Y N Hepatitis
 Y N High blood pressure
 Y N Immune system disorder
 Y N Injury to
 Face Neck
 Head Mouth Teeth
 Y N Insomnia
 Y N Irregular heart beat
 Y N Jaw joint surgery
 Y N Low blood pressure
 Y N Memory loss
 Y N Migraines
 Y N Morning dry mouth
 Y N Muscle spasms or
 cramps
 Y N Needing extra pillows to
 help breathing at night
 Y N Nighttime sweating

- Y N Osteoarthritis
 Y N Osteoporosis
 Y N Poor circulation
 Y N Prior orthodontic treatment
 Y N Recent excessive weight
 gain
 Y N Rheumatic fever
 Y N Shortness of breath
 Y N Swollen, stiff or painful
 joints
 Y N Thyroid problems
 Y N Tonsillectomy (have had)
 Y N Wisdom teeth extraction

Other medical history:

Patient Signature _____

Date _____

Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center? Yes No

If Yes:

Sleep Center Name _____
and Location _____

Sleep Study Date _____

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The evaluation confirmed a diagnosis of: *mild*
 moderate obstructive sleep apnea
 severe

The evaluation showed an RDI of _____ and an AHI of _____

CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

- mask leaks
- I was unable to get the mask to fit properly
- discomfort caused by the straps and headgear
- disturbed or interrupted sleep caused by the presence of the device
- noise from the device disturbing my sleep and/or bed partner's sleep
- CPAP restricted movements during sleep
- CPAP does not seem to be effective
- pressure on the upper lip causing tooth related problems
- a latex allergy
- claustrophobic associations
- an unconscious need to remove the CPAP apparatus at night

Other: _____

Other Therapy Attempts

What other therapies have you had for breathing disorders?
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

Patient Signature _____

Date _____

Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height _____ age _____

weight _____ male/female _____

2. Do you snore?

- yes
 no
 don't know

If you snore:

3. Your snoring is?

- slightly louder than breathing
 as loud as talking
 louder than talking
 very loud. Can be heard in adjacent rooms

4. How often do you snore?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

5. Has your snoring ever bothered other people?

- yes
 no

6. Has anyone noticed that you quit breathing during your sleep?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

7. How often do you feel tired or fatigued after your sleep?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?

- yes
 no

If yes, how often does it occur?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

10. Do you have high blood pressure?

- yes
 no
 don't know

(For office use)

Scoring Questions: Any answer within the box outline is a positive response

Scoring categories:

Category 1 is positive with 2 or more positive responses to questions 2-6

Category 2 is positive with 2 or more positive responses to questions 7-9

Category 3 is positive with 1 positive response and/or a BMI > 30

(BMI = Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

✓ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>Total Score: _____</p> <p><i>(Add columns 0-3)</i></p>

Patient Signature _____

Date _____



PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

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