Informed Consent for the Treatment of Snoring Symptoms with the myTAP Oral Appliance

Snoring and Obstructive Sleep Apnea (OSA) are both breathing disorders that occur during sleep due to narrowing or total closure of the airway. The disorders are on the continuum Sleep Disordered Breathing. Snoring is a noise created by the partial closure of the airway and may often be no more problematic than the noise itself. OSA is a serious condition; the airway totally closes many times during the night and can result in excessive daytime sleepiness, irregular heartbeat, high blood pressure, reflux, depression, occasionally heart attack or stroke.

TREATMENT WITH ORAL APPLIANCES:

Oral appliances may be helpful in the treatment of snoring, upper airway resistance syndrome (UARS), and sleep apnea. Oral appliances are designed to assist breathing by keeping the jaw and tongue forward, thereby opening the airway space in the throat. While documented evidence exists that oral appliances have substantially reduced snoring and sleep apnea for many people, there are no guarantees this therapy will be successful for every individual. Several factors contribute to the snoring/apnea condition including nasal obstruction, narrow airway space in the throat and excess weight. Because each person is different and presents with unique circumstances, oral appliances will not reduce snoring and/or apnea for everyone.

POSSIBLE COMPLICATIONS:

Some people may not be able to tolerate the appliance in their mouths. Some people will develop temporary adverse side effects such as excessive salivation, sore jaw joints, sore teeth and slight change in their “bite”. However, these usually diminish within an hour after the appliance is removed in the morning. On a rare occasion, a permanent “bite “change may occur due to jaw joint changes and/or movement. Generally, this can be prevented with the AM Aligner or other techniques you may be shown. These complications may or may not be fully reversible once appliance therapy is discontinued. If not, restorative, orthodontic, and/or surgical treatment may be required for which you are responsible. Oral appliances can wear and break. It is possible that these or broken parts from them may be swallowed or aspirated.

LENGTH OF TREATMENT:

The oral appliance is strictly a mechanical device to maintain an open airway during sleep. It does not cure snoring or sleep apnea. Therefore the device must be worn nightly for a lifetime to be effective. Over time, simple snoring may develop into sleep apnea. Sleep apnea also may become worse. Therefore, the appliance may not maintain its effectiveness. The oral appliance needs to be checked at least once a year to ensure proper fit and the mouth examined at the time to assure a healthy condition. If any unusual symptoms occur, you are advised to schedule an office visit to evaluate the situation.

ALTERNATIVE TREATMENTS:

Other accepted treatments for sleep-disordered breathing include behavior modification, weight loss, constant positive airway pressure, and surgery. You have chosen oral appliance therapy to treat your particular problem and are aware that it may not be completely effective for you.

USUAL OCCURRENCES:

As with any form of medical or dental treatment, unusual occurrences can and do happen. Broken or loosened teeth, dislodged dental restorations, mouth sores, periodontal problems, root resorptions, non-vital teeth, muscle spasms, and ear problems are all possible occurrences. Most of these complications and unusual occurrences are infrequent. Additional medical and dental risks that have not been mentioned may occur. Good communication is essential for the best treatment results. Please consult your prescriber if you have any questions or problems regarding treatment.

SNORING TREATMENT ONLY:

I understand that I am being treated for my snoring alone. I have been informed of a risk for sleep apnea. Although a recommendation has been made for testing, I have chosen not to be tested by either home sleep test (HST) or polysomnography (PSG) (overnight sleep study) and that I may or may not have sleep apnea.

I certify that I will read, or have read to me, the contents of this form. I realized and accept any risks and limitations involved, and do consent to treatment. I certify that I have read and understand the warnings on the myTAP package and in the instructions. Please sign in the presence of office personnel.

Date: _____Patient:_____

Date: _____Witness:_____