MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Treatment Agreement for Oral Appliance Therapy:
Snoring and Obstructive Sleep Apnea

Please read and understand the information on pages 1-3 before signing this agreement.

1) My doctor has told me I have snoring or obstructive sleep apnea.

2) My doctor recommends an oral appliance to manage the snoring or obstructive sleep apnea.
   An oral appliance is designed to help breathing by keeping the tongue forward, opening the airway space in the throat. People with mild or moderate obstructive sleep apnea are more likely to benefit from oral appliances than those with a severe condition.

3) I understand there are **risks to using an oral appliance**. The most common or serious side effects or risks are:

Common and temporary side effects and risks:	Less common risks that are serious or permanent:
• Inability to tolerate the appliance in the mouth • Excessive salivation • Sore jaw joints or teeth • Slight bite changes	• Permanent bite changes requiring dental treatment • Cause or worsen a temporomandibular joint disorder

4) My dentist or doctor has explained:
   a) The risks of an oral appliance
   b) The risks of refusing an oral appliance

c) Alternatives to using an oral appliance (including no treatment) and their risks.

d) I have decided to pursue oral appliance therapy.

5) I request and authorize Michigan Medicine and any doctors, nurses, dental residents and other trainees, technicians, assistants or others who may be assigned to my case **to participate in providing the oral appliance and management**.

6) I also understand that Michigan Medicine is a teaching hospital and that **medical and other students participate in procedures** as part of their education. By signing this form, I agree to allow students to participate in providing my oral appliance and management.

7) I understand that the practice of dentistry is not an exact science. There is documented evidence that oral appliances can greatly reduce snoring and obstructive sleep apnea, **but no promises or guarantees** have been made or can be made to me about my response. Each patient is different. Factors like nasal obstruction, narrow air space in the throat, and excess weight may all contribute to snoring and obstructive sleep apnea.

8) Fitting for the oral appliance will be performed or supervised by:

_____ ID #: _____.

Additional information on snoring, obstructive sleep apnea, and use of oral appliances for treatment:

- Snoring and obstructive sleep apnea are breathing disorders that occur during sleep due to narrowing or closure of the airway.

- Snoring is a noise created by partial closure of the airway and may not be a symptom of any dangerous condition. However, consistent, loud, heavy snoring has been linked to medical disorders like high blood pressure.

- Obstructive sleep apnea is a serious condition in which the airway totally closes many times during sleep. Obstructive sleep apnea can greatly reduce oxygen levels in the body and disrupt sleep. This can result in excessive daytime sleepiness, irregular heartbeat, high blood pressure, and heart diseases, including heart attack or stroke.

Exercise and Follow-up Are Very Important!

- It is important to do jaw opening exercises to bring the bite back to normal after use of the oral appliance. Pushing up and back on the chin while opening and closing can help. It is important for each patient to sense biting on the back teeth each morning.

- An oral appliance must be checked routinely to ensure a proper fit. The mouth and teeth should also must be examined at that time.

- If any unusual symptoms occur, it is best not to wear the oral appliance again until an office visit can be scheduled to evaluate the situation.

- Even if you feel more alert and refreshed after using the oral appliance, **the only way to accurately measure whether it is keeping your oxygen level high enough to prevent abnormal heart rhythms is to have a consultation with a sleep specialist and a follow-up sleep test while wearing the appliance. This is an expectation for all patients with snoring and/or obstructive sleep apnea**.

I read and understood the information above before signing it. My questions have been answered. I accept the risks listed above or discussed with my dentist or other health professional.

For patient:

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name of LAR *(proof of authority may be required)*

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Next of Kin

☐ Other
*(specify)*_____

_____

For Medical Personnel Only:

Consent **Obtained/Explained/Witnessed** By *(Signature)* _____

ID # _____ ☐ Attending MD/DDS ☐ Resident ☐ Nurse ☐ PA

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