Stop Bang Sleep Test Questionnaire

Please answer all quesions	YES	NO
Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	○	○
Tired: Do you often feel tired, fatigued or sleepy during daytime?	○	○
Observed: Has anyone observe you stopping breathing during your sleep?	○	○
Blood pressure: Do you have or are you being treated for high blood pressure?	○	○
BMI: Is your BMI more than 35kg/m^2?	○	○
Age: Are you over 50 years old?	○	○
Neck Cimrcumferce: Is your neck circumference greater than 40cm/15¾"?	○	○
Gender: Are you male?	○	○

Show Total ☐ is your score. Below 3 = low risk. 3 and above = high risk.

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Epworth Sleepiness Scale (ESS) Sleep Test Questionnaire

	0	1	2	3
Please answer all quesions	**Would never doze**	**Slight chance of dosing**	**Moderate chance of dosing**	**High chance of dosing**
Sitting & reading	○	○	○	○
Watching television	○	○	○	○
Sitting inactive in public place, for example a theatre or meeting	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quitely after lunch (when you've had alcohol)	○	○	○	○
In a car while stopped in traffic	○	○	○	○

Show Total ☐ is your score. Scores above nine indicate the need for a sleep specialist.

Name: _____ Date: _____

Informed Consent for the Treatment of Sleep-Related Breathing Disorders

You have been diagnosed by your physician as requiring treatment for a sleep-related breathing disorder, such as snoring and/or obstructive sleep apnea (OSA). OSA may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels. This condition can increase a person's risk for excessive daytime sleepiness, driving and work-related accidents, high blood pressure, heart disease, stroke, diabetes, obesity, memory and learning problems, and depression.

What is Oral Appliance Therapy?

Oral appliance therapy for snoring and/or OSA attempts to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. OAT has effectively treated many patients. However, there are no guarantees that it will be effective for you. Every patient's case is different and there are many factors that influence the upper airway during sleep. 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 symptoms related to your sleep-related breathing disorder.

A post-adjustment polysomnogram (sleep study) is necessary to objectively assure effective treatment. This must be obtained from your physician.

Side-Effects and Complications of Oral Appliance Therapy

Published studies show that short-term side effects of oral appliance therapy may include excessive salivation, difficulty swallowing (with appliance in place), sore jaws or teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth, and short-term bite changes. 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 oral appliance therapy is discontinued. If not reversible, restorative treatment or orthodontic intervention may be required for which you will be responsible.

Follow-up visits with the provider of your oral appliance are mandatory to ensure proper fit and 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 that you cease using the appliance until you are evaluated further.

Alternative Treatments for Sleep-Related Breathing Disorders

Other accepted treatments for sleep-related breathing disorders include behavioral modification, Continuous Positive Airway Pressure (CPAP) and various surgeries. It is your decision to choose oral appliance therapy to treat your sleep-related breathing disorder 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-related breathing disorders may increase the likelihood of significant medical complications.

If you understand the explanation of the proposed treatment, have asked this provider any questions you may have about this form or treatment, please sign and date this form below. You will receive a copy.

Signature: _____ Date: _____

Print Name: _____

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Affidavit for Intolerance or Non Compliance to CPAP

I, _____, have attempted to use CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder (OSA-Obstructive Sleep Apnea) and find it intolerable to use on a regular basis for the following reason(s):

- ❑ Mask Leaks
- ❑ An Inability 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 sleep or bed partner's sleep
- ❑ CPAP restricted movements during sleep
- ❑ CPAP does not seem to be effective
- ❑ Pressure on the upper lip causes tooth related problems
- ❑ Latex allergy
- ❑ Claustrophobic associations
- ❑ An unconscious need to remove the CPAP apparatus at night
- ❑ Other _____

Because of my intolerance / inability to use the CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device

Signed: _____

Dated: _____