SOMNOPLASTY

Somnoplasty is an approved treatment for snoring in which the soft tissues in the oral passage are reduced and stiffened with heat.

Patient's Initials

_____ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks, and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of somnoplasty have been discussed with me and may include but are not limited to:

- *inability to swallow*
- *infection*
- *oral and throat discomfort*
- *scarring of the throat causing narrowness*
- *swelling*
- *voice change*
- *worsening of snoring*

_____ I am aware that the effective duration of the procedure is unknown, and repeat procedures may be necessary.

_____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.

_____ I have informed the doctor of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, or any other recreational drug or alcohol use.

_____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

_____ I am aware that the procedure will take place in the physician's office and that I will receive a local anesthetic for numbing.

_____ I am aware and accept that no guarantees about the results of the procedure have been made.

_____ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

_____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, MD, with associates or assistants of his or her choice, to perform somnoplasty on _____ at_____.
(*patient name*) (name of facility)

I further authorize the physician(s) and assistants to do any other procedures that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

_____ _____
Patient or Legal Representative Signature/Date/Time Relationship to Patient

Continued

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

Physician Signature/Date/Time

_____ copy given to patient
initial

_____ original placed in chart
initial