



DLP use only / <i>Usage DLP</i>	Internal use only / <i>Usage interne</i>				Reçu le:				N° Série
Name:	DEP	Chèq	Poste	TNT	Modèle	PE	GG	Mordu	
FTP order #:									
Date:									

# Order form for Narval CC™

# ANGLETERRE

## PATIENT INFORMATION / INFORMATIONS PATIENT

Name / *Nom* \_\_\_\_\_ First Name / *Prénom* \_\_\_\_\_

**Patient is reimbursed by the social security / OSA indication** *Remboursé / indication SAOS*

**Patient is not reimbursed / snoring indication** *Non remboursé / indication ronflement*

## SLEEP DOCTOR INFORMATION / MEDECIN SPÉCIALISTE DU SOMMEIL

Name / *Nom* \_\_\_\_\_ First Name / *Prénom* \_\_\_\_\_

## PROTRUSION SETTINGS / RÉGLAGE DE LA PROPULSION

**RENEWAL:** This patient was fitted with Narval CC™ in the past / *Renouvellement*

In this case we produce a **new MRD** based on the data provided on this order form, please make sure that you fully complete it with protrusion settings and design preferences expectations.

**BITE REGISTRATION IN DESIRED PROTRUSION** *Mordu en prop souhaitée*

Narval CC initial mandibular protrusion will be set according to the bite registration recorded

Reduce the vertical dimension to the maximum (ResMed recommended option)

*Reduire la DV*

We will reduce it to a minimum of 4 mm to allow proper design of the splints

OR

Reproduce the vertical dimension recorded by the bite registration

*Reproduire la DV*

A minimum of 4 mm will be needed to allow proper design of the splints

OR

**MEASUREMENTS IN MAXIMUM PROTRUSION** *Mesures en prop max*

Narval CC Initial mandibular protrusion will be set at approx. 60% of maximum protrusion

Distance from incisor 11 to 41: \_\_\_\_\_ mm

from end to end in maximum protrusion

*Distance entre les incisives maxillaires et mandibulaires*



Midline deviation: \_\_\_\_\_ mm

in maximum protrusion

*Déviations des milieux inter-incisifs*

Right patient

*Droite*



Left patient

*Gauche*

In case of specific occlusion: Bite registration in centric occlusion

*Mordu en OIM*

**In case of renewal:** you can choose a specific Narval CC protrusion setting: \_\_\_\_\_ % of maximum protrusion  
*En cas de renouvellement, % de la prop. max. à réaliser*

## DENTAL PARTICULARITIES TO BE TAKEN INTO ACCOUNT / PARTICULARITÉS DENTAIRES À NOUS SIGNALER

Teeth to protect:

*Dents à protéger*

Broken teeth:

*Dents cassées*

Future restoration (implant/crown) on teeth #:

*Restauration dentaire (implant/couronne) prévue sur dents N°*

Other (in English):

*Autre*

Complete lower denture mechanically retained (eg. by implants)

*Prothèse totale inférieure retenue mécaniquement*

Complete upper denture

*Prothèse totale supérieure*

Presence of removable partial denture(s) (see instructions

on impressions) / *Présence de prothèse(s) partielle(s) amovible(s)*

## DESIGN PREFERENCES / PRÉFÉRENCES DE DESIGN

Narval CC is available in 5 designs variation to better meet the specific anatomical constraints of your patients.

3 of the 5 designs are also available with anterior contact, but in all cases no retention is taken on anterior teeth.

Each design can be applied independently on the lower and on the upper splint.

**Without any design specification,** ResMed will select the design for you, prioritizing a non-contact facial band design unless the dental morphology requires a different design.

**If you choose a specific design,** ResMed will try to comply with your preference but might have to change in case the dental morphology requires a different design.

Without anterior contact

With anterior contact

FACIAL BAND Retentive teeth	FACIAL BAND WITH CAP Retroclined teeth	INCISOR FULL COVERAGE Low retentive teeth	PALATAL/LINGUAL BAND WITH CAP Proclined teeth	PALATAL/LINGUAL BAND Proclined teeth
Upper / H Lower / B	Upper / H Lower / B	Upper / H Lower / B	Upper / H Lower / B	Upper / H Lower / B
Not available	Upper / H Lower / B	Upper / H Lower / B	Upper / H Lower / B	Not available

Please cover all the molars (by default splints cover at least teeth #6 on the upper and #7 on the lower - extended coverage can be applied in case of low retention) / *Je souhaite inclure toutes les molaires*

Please add slots for elastic bands / *Je souhaite des encoches pour élastiques*

## PRACTITIONER SIGNATURE & DELIVERY TIME: 15 WORKING DAYS FROM RECEPTION OF YOUR ORDER BY RESMED SAS

Practitioner full name: *Nom et prénom du praticien*

By my signature, I confirm that I informed my patient, and he agrees, that his personal data will be processed by ResMed :

- For the purposes of manufacturing of the oral appliance, order follow up, post market surveillance, billing, payment, reimbursement process, warranty, claims investigation and after sales service

- To inform his sleep doctor that the oral appliance has been realized and shipped to me for fitting \_\_\_\_\_ My patient refused

- To conduct statistical analysis for Marketing and scientific publications purposes \_\_\_\_\_ My patient refused

I also informed my patient that he may have certain data rights under local data protection laws.

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Signature

Stamp

Delivery address: *Adresse de livraison*

Country: *Pays* \_\_\_\_\_ Tel: \_\_\_\_\_

Email: \_\_\_\_\_

Billing address (if different): *Adresse de facturation*

**PLEASE PROVIDE ALL INFORMATION REQUESTED. IF YOUR ORDER REMAINS INCOMPLETE, IT WILL BE CANCELLED AFTER A PERIOD OF 60 DAYS**

# Order form for Narval CC™

## 1. By signing this order form, you are confirming that the patient is a good candidate for a mandibular repositioning device.

Before prescribing patients with Narval CC™, you should look out for relevant issues in their medical history, such as respiratory disorders, asthma and breathing problems, and refer them to the appropriate healthcare provider first.

<p>The Narval appliance is contraindicated for patients who:</p> <p><b>General contraindications</b></p> <ul style="list-style-type: none"><li>• Have central sleep apnoea</li><li>• Have severe respiratory disorders (other than OSA)</li><li>• Are under 18 years of age</li></ul> <p><b>Dental contraindications</b></p> <ul style="list-style-type: none"><li>• Have loose teeth or advanced periodontal disease</li><li>• Have a completely edentulous lower arch unless a complete denture mechanically retained is present (e.g. retained by implants)</li><li>• Have a completely edentulous upper arch unless a complete upper denture is present</li><li>• Have short teeth and/or insufficient undercuts to retain the device.</li></ul>	<p>It is necessary to perform a dental, periodontal, prosthetic and TMJ examination. The following dental issues must be treated by the patient's regular dentist before MRD treatment:</p> <ul style="list-style-type: none"><li>• Periodontal disease</li><li>• Cysts and mouth ulcers</li><li>• Teeth that need to be extracted</li><li>• Prosthodontics – such as crown or bridge</li><li>• Orthodontics</li><li>• Temporomandibular pain needs to be further assessed by patient's treating physician as well as any other TMJ disorder.</li></ul> <p>The dental sleep specialist should check if the teeth (natural or dental implant) anchoring value and morphology are sufficient to ensure the efficacy of MRD without significant side effect of treatment.</p>
--	--

## 2. When sending this order form, you confirm that you have provided the following information:

### PROTRUSION SETTINGS

#### BITE REGISTRATION IN DESIRED PROTRUSION

- If you chose the option: "reduce the vertical dimension to the maximum", we will keep a minimum of 4 mm in order to allow proper design of the splints and to ensure no posterior contact during advancement.
- If you chose the option: "reproduce the vertical dimension recorded by the bite registration", your bite registration should be at least 4mm thick in order to allow proper design of the splints and to ensure no posterior contact during advancement.

#### MEASUREMENTS IN MAXIMUM PROTRUSION

- Please measure the distance between the upper incisor (N°11) and the lower incisor (N°41), from end to end, in mm and in maximum protrusion.
- Where applicable, please provide direction and distance of midline deviation in maximum protrusion.
- In order to ensure no posterior contact during advancement and to allow proper design of the splints, vertical dimension will be reduced to a minimum of 4 mm at the back.

### IMPRESSIONS AND/OR MODELS

#### IMPRESSIONS:

- The impression material chosen should not be affected by transport (**non-compressive silicone would be preferred for long distance and/or weekend transportation and alginate should only be used for short distance transportation**).
- We require a full impression of gingival sulcus and posterior molar area. Impressions must be taken **with dentures in place** (if any) and must show the bottom of the sulcus in the full dental arch.
- If the patient wears their removable partial denture during the night, please take the impressions with the removable partial denture in place. If the patient does not wear their removable partial denture during the night, please ensure that the anchoring value and morphology of the remaining teeth are sufficient. In case of doubt, please contact your ResMed approved Dental Laboratory Partner.

#### MODELS:

- Please **ONLY** use a Type IV high strength material that can be scanned by CAD/CAM systems (matt and light colour preferred), low expansion crown and bridge die stone that produces smooth, hard and accurate surfaces.
- Ensure bubbles are not present on the teeth surface or the gingival margin.
- **In case of renewal: we can use the previous models only if they are less than 2 years without any dental modifications (new crowns, restorations, missing teeth...).** Otherwise, please send new imprints.

## 3. Warranty

ResMed guarantees all Narval appliances supplied to be free from defects in materials and workmanship for a period of 2 years from the manufacturing date shown inside the Narval packaging.

For complete warranty conditions, please refer to the instructions for use.

## 4. Data privacy

ResMed will make a digital copy of the data gathered from this form. The data will be stored for 5 years and will be used by ResMed customer services. In accordance with applicable Data Protection Laws, you have the right to access, update, erase, suspend, export, or stop processing of your personal data. To exercise those rights, you can write to ResMed, Bureau du DPO, Parc Technologique de Lyon, Allée Jacques Monod, 69791 Saint-Priest Cedex, or email: "privacy.france@resmed.eu" specifying "Rights of individuals" as the subject.

## 5. Send your order to your local ResMed approved Dental Laboratory. More info can be provided by your ResMed contact.

<p><b>Complete this order form and send it out with:</b></p> <ul style="list-style-type: none"><li>- Disinfected bite registration and/or measurements</li><li>- Disinfected impressions or models</li></ul>	<p><b>Your ResMed approved Dental Laboratory</b></p>	<p><b>Your ResMed contact</b></p>
--	--	-----------------------------------