AFFIDAVIT FOR INTOLERANCE TO CPAP DEVICE

Patient: _____

Date: _____

I have attempted to use a CPAP device to manage my sleep-related breathing disorder and find it intolerable to use on a regular basis for the following reason(s):

- ☐ Mask Leaks
- ☐ Mask and/or device uncomfortable
- ☐ Unable to sleep comfortably
- ☐ Noise from the device disturbs me and/or my bed partner's sleep
- ☐ Restricts movement during sleep
- ☐ Does not seem to be effective
- ☐ Straps/headgear cause discomfort
- ☐ Pressure on upper lip causes tooth-related problems
- ☐ Latex allergy
- ☐ Claustrophobia
- ☐ Other: _____

I have not attempted to use a CPAP device and would prefer to use an oral appliance for the following reason(s):

- ☐ I'm worried that the mask, straps/headgear will cause discomfort
- ☐ I'm worried that the noise from the device will disturb me and/or my bed partner's sleep
- ☐ I'm worried that the device will restrict movement during sleep
- ☐ I have a latex allergy
- ☐ I suffer from claustrophobia
- ☐ I travel frequently and am worried that a CPAP device will be cumbersome to transport
- ☐ Other: _____

Because of my inability to use a CPAP device, I wish to have an alternative method of treatment. I would like to try an oral appliance in an attempt to control my snoring and obstructive sleep apnea.

X _____ _____

Patient's Signature Date