



AFFIDAVIT FOR CPAP INTOLERANCE

Patient's Name: _____

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 the mask, straps/headgear will cause discomfort
- I'm worried the noise from the device will disturb me and/or my bed partner's sleep
- I'm worried 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