Affidavit for Intolerance or Non-Compliance to CPAP

Patient name: _____

I have discussed CPAP with my physician and am refusing CPAP at this time. **YES NO**

I am not able to try and tolerate CPAP treatment at this time. **YES NO**

I prefer oral appliance vs CPAP if I am diagnosed with sleep apnea. **YES NO**

I have attempted to use CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder. **YES NO**

I prefer to use the oral appliance in combination with my CPAP to lower the pressure setting on my CPAP. **YES NO**

PLEASE SEE FOLLOWING REASONS FOR INTOLERANCE OR NON-COMPLIANCE:

- I cannot tolerate anything on face due to claustrophobia when sleeping.
- 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 and most likely wouldn't be able to keep it on.
- 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
- Cpap caused distended stomach, burping and /or irritated IBS symptoms.
- CPAP has caused lack of intimacy in my relationship.
- Difficulties sleeping after removing/replacing cpap after having to go to the bathroom
- Cannot travel with CPAP
- No electricity for usage of CPAP
- Latex allergy Other: _____
- I have attempted the following due to my sleep apnea/snoring (Please circle):
  Nasal Strips Nose cones Positional Therapy (Changing positions while sleeping) Dieting/Weight loss

Because of my intolerance and/or inability to use or try the CPAP or because I am refusing CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device.

Signed: _____Date: _____