



Affidavit for Intolerance to CPAP

I have previously been tested and diagnosed with Obstructive Sleep Apnea (OSA). The diagnosis was in the range of:

Mild Moderate Severe Do not recall

I **attempted / refuse (circle the one that applies)** to use nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reason(s):

- Mask leaks or inability to get the mask to fit properly
- Discomfort or aversion to mask and device
- Inability to fall asleep or interrupted sleep due to the presence of the device
- Noise from the device disturbing sleep or bed partner's sleep
- CPAP does not seem to be effective
- Pressure on the upper lip causes tooth related problems
- Latex allergy
- Claustrophobic associations
- Unconscious need to remove the CPAP at night

Other: _____

I have also unsuccessfully attempted: _____

Because of my intolerance/inability/refusal to use the CPAP and/or other treatment, I wish to have an alternative method of treatment. That form of therapy is oral appliance therapy (OAT).

Print Name: _____

Signature: _____ Date: _____