

Affidavit of Intolerance to CPAP (Continuous Positive Air Pressure)

Patient's Name: _____ Date: _____

I have attempted to use nasal CPAP to manage my sleep disordered breathing (obstructive sleep apnea) and find it intolerable to use on a regular basis, due to the following reason(s).

- CPAP is not effective in controlling my symptoms.
- I am unable to sleep with the CPAP equipment in place.
- The noise from the device disturbs my sleep and/or my bed partner's sleep.
- I cannot find a comfortable mask.
- The mask leaks.
- I develop sinus/ throat/ ear/ lung infections.
- I am allergic to materials in the mask and head strap.
- Claustrophobia
- I unconsciously remove the CPAP apparatus at night.
- The pressure of the mask and straps causes tissue breakdown.
- My job and/or life style prevent this form of therapy. (i.e. Active Army, Medical Profession)
- Prior throat surgery made CPAP intolerable.
- Other reason: _____

Because of my inability to tolerate CPAP and my need to control the signs and symptoms of OSA, I wish to use an alternative method of treatment. This form of therapy is oral appliance therapy (OAT).

SIGNATURE OF PATIENT

TODAY'S DATE