CPAP INTOLERANCE AFFIDAVIT

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 device disturbs me and/or my partner's sleep
- ☐ Restricts movement during sleep
- ☐ Does not seem to be effective
- ☐ Straps/headgear cause discomfort
- ☐ Pressure on upper lip cause 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):

- ☐ Worried the mask, straps/headgear will cause discomfort
- ☐ Worried the noise from device will disturb me and/or my partner's sleep
- ☐ Worried device will restrict movement during sleep
- ☐ Latex allergy
- ☐ Claustrophobia
- ☐ Travel frequently and am worried a CPAP device will be cumbersome to transport
- ☐ Other: _____

☐ I have **not attempted to use a CPAP device and am refusing CPAP treatment**. An oral appliance is the only sleep apnea treatment I will use.

☐ I have **attempted to use a CPAP device and am refusing to continue CPAP treatment**. An oral appliance is the only sleep apnea treatment I will use.

Patient Name: _____ Patient Signature: _____ Date:_____

Witness Name: _____ Witness Signature: _____ Date:_____

Additional Notes:

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