CPAP INTOLERANCE AFFIDAVIT

Patient Name: _____

I, _____, make my statement and General Affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts, and things set forth are true and correct to the best of my knowledge.

I have been prescribed the nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis due to the following reason (s):

- ❒ Mask Leaks
- ❒ Mask is uncomfortable /device is uncomfortable
- ❒ Unable to sleep comfortably
- ❒ Noise disturbs sleep and /or bed partner's sleep
- ❒ Movement is restricted during sleep
- ❒ Does not seem to be effective
- ❒ Straps /Headgear cause discomfort
- ❒ Pressure in the upper lip causes tooth related problems
- ❒ Latex allergy
- ❒ Claustrophobia
- ❒ Other: _____

Because of my intolerance /inability to use the CPAP, I wish to have an alternative method of treatment. The method of treatment is an Oral Airway Dilator Appliance, as prescribed to me by Dr._____.

Patient Signature: _____ Date: _____/____ /_____

Witness Signature: _____Date: _____/____ /_____