CPAP Intolerance Affidavit

CPAP Intolerance

Patient Name: ______________________________ Date of Birth: ____________________

I have experienced the following problems after attempting to wear CPAP for my obstructive sleep apnea:

- ☐ Mask Leaks (attempts to repair or replace the mask have been made without improvement)
- ☐ An Inability to get the mask to fit properly (attempts to repair or replace the mask have been made without improvement)
- ☐ Allergy, significant discomfort or skin irritation caused by the straps and/or headgear
- ☐ Disturbed or interrupted sleep caused by the presence of the device
- ☐ Noise from the device significantly disturbing sleep or bed partner's sleep
- ☐ Machine significantly restricted movements during sleep
- ☐ CPAP has been ineffective relieving symptoms
- ☐ Pressure on the upper lip causes tooth related problems
- ☐ The use of the machine or the very thought of using the machine caused claustrophobic associations
- ☐ An unconscious need to remove the apparatus at night
- ☐ Unable to tolerate the prescribed level of pressure (multiple levels/attempts were unsuccessful)
- ☐ Repeated upper respiratory infections caused by use of the machine

Other reasons for CPAP intolerance:

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I have not attempted CPAP therapy for my obstruvtive sleep apnea, however:

- ☐ An oral appliance has been recommended or prescribed by a medical provider as a first line treatment for mild-moderate OSA
- ☐ I am unable to use/wear CPAP due to an underlying medical condition

Other reasons for attempting oral appliance before CPAP:

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Affidavit Statement

I attest that the reason(s)/condition(s) above apply to me and given those selected, I wish to have my obstructive sleep apnea treated with a custom fitted, adjustable oral appliance from a qualified dentist if prescribed by my physician. I understand that an oral appliance can be effective as a first line treatment for mild to moderate obstructive sleep apnea.

I also acknowledge that if I have been diagnosed with severe obstructive sleep apnea or have other medical conditions with my obstructive sleep apnea that warrant CPAP or BiPAP use, one of these modalities was recommended to me as the most appropriate first line treatment option. I understand that an alternative treatment option, such as the oral appliance, may not be as effective as PAP therapy in these specific circumstances.

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Signature of Patient or Guardian

Patient Name: ______________________________

Name of Guardian (if signed): ______________________________

Date: ____________________