ASHTABULA SLEEP MEDICINE

# 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 / refused (Check the ones that apply) 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 presence of 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

____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.

Print Name: _____

Signature: _____ Date: _____

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