AFFIDAVIT TO INTOLERANCE OF WEARING A CPAP

Patient Name: ____

I, ____, make this 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 reasons(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 on 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. That method of treatment is an Oral Airway Dilator Appliance, as prescribed to me by Dr. ________________________________.

______________________________ ______________________________

Patient Signature Witness Signature

Date:___________________________