

Affidavit for Intolerance or Non Compliance to CPAP

I, _____, have attempted to use or can not use CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder (OSA-Obstructive Sleep Apnea) and find it / will find it intolerable to use on a regular basis for the following reason(s):

- Mask Leaks
- An Inability to get the mask to fit properly
- Discomfort caused by the straps and headgear
- Disturbed or interrupted sleep caused by the presence of the device
- Noise from the device disturbing sleep or bed partner's sleep
- CPAP restricted movements during sleep
- CPAP does not seem to be effective
- Pressure on the upper lip causes tooth related problems
- Latex allergy
- Claustrophobic associations
- An unconscious need to remove the CPAP apparatus at night
- Other _____

Because of my intolerance / inability to use the CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device

Signed: _____

Dated: _____