

Patient Name: _____

AFFIDAVIT FOR INTOLERANCE TO CPAP

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 true and correct to the best of my knowledge.

Dr. _____ has prescribed the nasal CPAP to manage my sleep-related breathing disorder (apnea) and it has been advised that it is the GOLD STANDARD OF CHOICE for treatment of Obstructive Sleep Apnea.

I have attempted to use a CPAP/BIPAP/APAP and find it intolerable to use on a regular basis for the following reason(s).

(PLEASE SELECT ALL THAT APPLY)

- Mask Leaks
- Mask and/or device uncomfortable
- Unable to sleep comfortably
- Noise from the device disturbs me and/or my bed partner's sleep
- Restricts movement during sleep
- Does not seem to be effective
- Straps/Headgear cause discomfort
- Pressure on upper lip causes tooth-related problems
- Latex Allergy
- Claustrophobia
- Other: _____

I have NOT attempted to use a CPAP/BIPAP/APAP device and would prefer to use an oral appliance, the following reason(s). (PLEASE SELECT ALL THAT APPLY)

- I'm worried that the mask, straps/headgear will cause discomfort.
- I'm worried that the noise from the device will disturb me and/or my bed partner's sleep
- I'm worried that the device will restrict movement during sleep
- I have a latex allergy
- I suffer from claustrophobia
- I travel frequently and am worried that a CPAP/BiPAP/APAP device will be cumbersome to transport.
- Other: _____

By signing this consent form you acknowledge that you have been made aware of reasonable alternatives to MAD therapy for obstructive sleep apnea including, but not limited to: tracheotomy; CPAP; oral or pharyngeal surgery; positional sleep therapy; weight loss and exercise. Additionally, you are aware that more than one treatment may be necessary for the best results.

Signed: _____ Date: _____ Witness: _____