CPAP INTOLERANCE / NON-COMPLIANCE AFFIDAVIT

FIRST NAME	LAST NAME	DOB

☐ **It has been recommended that I use CPAP therapy to manage my diagnosed Obstructive Sleep Apnea condition and I REFUSE to do so for the following reasons:**

☐ **I have attempted to use CPAP to manage my diagnosed Obstructive Sleep Apnea condition. I find CPAP intolerable to use on a regular basis due to the following reasons:**

- ☐ CPAP NOISE DISRUPTS MY AND/OR BED PARTNERS SLEEP
- ☐ PRESSURE ON LIP CAUSES TOOTH RELATED PROBLEMS
- ☐ RESTRICTED MOVEMENTS DURING SLEEP
- ☐ CLAUSTROPHOBIC ASSOCIATIONS
- ☐ UNABLE TO SLEEP COMFORTABLY
- ☐ CPAP NOT EFFECTIVE
- ☐ LATEX ALLERGY
- ☐ AN UNCONSCIOUS NEED TO REMOVE THE CPAP AT NIGHT
- ☐ DISTURBED SLEEP CAUSED BY PRESENCE OF DEVICE
- ☐ DISCOMFORT FROM STRAPS/MASK
- ☐ MASK UNABLE TO FIT PROPERLY
- ☐ MASK LEAKS
- ☐ OTHER: ______________________________

LIST ANY OTHER THERAPIES (LIFESTYLE CHANGES, WEIGHT LOSS ATTEMPTS, SMOKING CESSATION FOR AT LEAST ONE MONTH, SURGERIES, ETC.) YOU HAVE HAD FOR BREATHING DISORDERS:

BECAUSE OF MY INTOLERANCE/INABILITY OR REFUSAL TO USE CPAP THERAPY, I WISH TO HAVE AN ALTERNATIVE METHOD OF TREATMENT. THAT FORM OF THERAPY IS AN ORAL APPLIANCE AS PRESCRIBED BY DR. ______________

PATIENT SIGNATURE	DATE

SLEEP CERTIFIED

Rev: SC-08-CPAPIntoleranceNon-ComplianceAffidavit.docx

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