Affidavit for Intolerance or Non Compliance to CPAP

I, ________________________, have (have not) attempted to use CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder (OSA-Obstructive Sleep Apnea) and 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
- ❑ I have not tried CPAP, but choose the Oral Appliance as first line therapy.
- ❑ 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: ____