SLEEP GROUP SOLUTIONS

CPAP Intolerance / Non-Compliance Affidavit

Patient Name: _____

Date: ____/____/_____

It has been recommended and/or I have attempted to use CPAP (Continuous Positive Air Pressure) to manage my diagnosed Obstructive Sleep Apnea condition. I find CPAP intolerable to use on a regular basis due to the following reason(s):

- ____ The Mask Leaks
- ____ I am unable to sleep with the CPAP mask and equipment in place
- ____ I unconsciously remove the CPAP at night
- ____ The noise from the device disturbs my sleep
- ____ CPAP does not seem to be effective in reducing/eliminating my symptoms
- ____ I have tried multiple masks and none are comfortable enough to use
- ____ I develop sinus/ear/throat infections
- ____ I am claustrophobic
- ____ My job/lifestyle prevent nightly use (Army, Reserves, Truck Driver)
- ____ Other _____

Because of my intolerance and inability for CPAP to effectively treat my condition, I wish to attempt an alternative therapy. As per the 2006 practice parameters from the American Academy of Sleep Medicine I wish to utilize an oral airway dilator appliance to treat my obstructive sleep apnea.

Patient Signature: _____ Date: ____/____/_____