snooze sleep center

Carabelli DENTAL

# Affidavit for Intolerance or Non Compliance to CPAP

Patient name: _____ Date:_____

| | |
|---|---|
| **I have discussed CPAP with my physician and am refusing CPAP at this time.** | **YES NO** |
| **I am not able to try and tolerate CPAP treatment at this time.** | **YES NO** |
| **I prefer oral appliance vs CPAP if I am diagnosed with sleep apnea.** | **YES NO** |
| **I have attempted to use CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder.** | **YES NO** |
| **I prefer to use the oral appliance in combination with my CPAP to lower the pressure setting on my CPAP.** | **YES NO** |

PLEASE SEE FOLLOWING REASONS FOR INTOLERANCE OR NON COMPLIANCE:

- o I cannot tolerate anything on face due to claustrophobia when sleeping.
- o Mask Leaks
- o An inability to get the mask to fit properly
- o Discomfort caused by the straps and headgear
- o Disturbed or interrupted sleep caused by the presence of the device and most likely wouldn't be able to keep it on.
- o Noise from the device disturbing sleep or bed partner's sleep
- o CPAP restricted movements during sleep
- o CPAP does not seem to be effective
- o Pressure on the upper lip causes tooth related problems
- o Cpap caused distended stomach, burping and /or irritated IBS symptoms.
- o CPAP has caused lack of intimacy in my relationship.
- o Difficulties sleeping after removing/replacing cpap after having to go to the bathroom
- o Cannot travel with CPAP
- o No electricity for usage of CPAP
- o Latex allergy Other: _____
- o I have attempted the following due to my sleep apnea/snoring (Please circle):

Nasal Strips Nose cones Positional Therapy (Changing positions while sleeping) Dieting/Weight loss

Because of my intolerance and/or inability to use or try the CPAP or because I am refusing CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device.

Signed: _____Date: _____