## General Affidavit for CPAP Intolerance

Patient Name: ____________________________

I, ______________________ make my statement and General Affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts and things set forth are true and correct to the best of my knowledge.
I have been prescribed the CPAP to manage my sleep related breathing disorder and find it intolerable to use on a regular basis due to the following reason (s):

_____Mask leaks
_____Mask is uncomfortable/device is uncomfortable
_____Unable to sleep comfortably
_____Noise disturbs sleep and/or bed partner's sleep
_____Movement is restricted during sleep
_____Does not seem to be effective
_____Straps/headgear cause discomfort
_____Pressure on the upper lip causes tooth related problems
_____Latex allergy
_____Claustrophobia
_____Preexisting sinus condition
_____Other

Because of my intolerance/inability to use the CPAP, I wish to have an alternative method of treatment. That method of treatment is an Oral Airway Dilator, as prescribed to me by Dr. _________________.

________________________________ ________________________
Patient signature Witness signature

Date _____/______/______

*OSA 2-8*