SLEEP GROUP SOLUTIONS

CPAP Intolerance / Non-Compliance Affidavit

Patient Name: _____

Date: ____/____/_____

_____ It has been recommended that I use CPAP (Continuous Positive Air Pressure) to manage my diagnosed Obstructive Sleep Apnea condition and I refuse to do so for the following reason(s):

_____ 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 to comply with CPAP to effectively treat my condition, I wish to utilize an oral airway dilator appliance (E0486) to treat my obstructive sleep apnea.

Patient Signature:_____ Date:____/____/_____