Dental Solutions
a whole health approach

AFFIDAVIT FOR INTOLERANCE TO CPAP

***NAME*_____**

I have attempted to use nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reason(s):

_____ ***Mask leaks***

_____ ***Mask uncomfortable/Device uncomfortable***

_____ ***Unable to sleep comfortably***

_____ ***Noise disturbs my sleep and/or bed partners sleep***

_____ ***Restricts movement during sleep***

_____ ***Does not seem to be effective***

_____ ***Straps/headgear cause discomfort***

_____ ***Pressure on the upper lip cause tooth related problems***

_____ ***Other*** _____

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

Signed _____

Date _____

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