NOVA OROFACIAL PAIN, TMD & DENTAL SLEEP MEDICINE

NOVA Orofacial Pain, TMD & Dental Sleep Medicine
CPAP Intolerance/Non-Compliance Affidavit

Patient Name: _____ Date: ____/_____/_____

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

_____ The Mask Leaks

_____ Mask and/or device is uncomfortable

_____ I cannot sleep with the CPAP mask and equipment in place

_____The noise from the device disturbs me and/or my bed partner's sleep

_____CPAP does not seem to be effective in reducing/eliminating my symptoms

_____I have tried multiple masks and none are comfortable to use

_____I developed sinus/ear/throat infections

_____I am claustrophobic

_____I have an allergy to the mask material

_____My job/lifestyle prevents nightly use (Army, Reserves, Truck Driver)

_____***I no longer wear the CPAP device

_____Other_____

I have not attempted to use a CPAP device and would prefer to use an oral appliance for the following reason(s):

_____ I suffer from claustrophobia

_____ I have an allergy to the mask material

_____ I travel frequently and am worried that a CPAP device will be cumbersome to transport

_____ I am worried that the CPAP will be uncomfortable and disturb myself or bed partner

_____ I have mild to moderate OSA and was informed by my physician that an oral device is equivalent

Because of my intolerance or inability to use CPAP to effectively treat my condition, I wish to utilize an adjustable mandibular oral appliance (E0486) to treat my obstructive sleep apnea.

Patient Signature: _____ Date: ____/____/____