



Dedicated Sleep

AFFIDAVIT FOR INTOLERANCE TO PAP

Check the following that applies:

\_\_\_ I have NOT attempted to use the nasal PAP to manage my sleep related breathing disorder (apnea) and feel it would be intolerable to use for the following reasons (check all that apply below):

\_\_\_ I HAVE attempted to use the nasal PAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons (check all that apply below):

Amount of time PAP was used: \_\_\_\_\_

\_\_\_ Mask leaks

\_\_\_ An inability to get the mask to fit properly

\_\_\_ Discomfort or interrupted sleep caused by the presence of the device

\_\_\_ Noise from the device disturbing sleep or bed partner's sleep

\_\_\_ CPAP restricted movements during sleep

\_\_\_ CPAP does not seem to be effective

\_\_\_ Pressure on the upper lip causes tooth related problems

\_\_\_ Latex allergy

\_\_\_ Claustrophobic associations

\_\_\_ An unconscious need to remove the PAP apparatus at night

\_\_\_ Other (Please describe): \_\_\_\_\_

\_\_\_\_\_

Based on my intolerance/inability to use PAP, I wish to have the alternative treatment, oral appliance therapy (OAT).

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_