TOTAL HEALTH SLEEP SOLUTIONS, INC.

87 S. McLean Blvd., Suite B – South Elgin, IL 60177 – P: 847.888.8311 - F: 847.429.9334

Affidavit for Intolerance or Non-Compliance to CPAP

Patient Name _____ DOB _____

I have attempted to use CPAP (Continuous Positive Air Pressure) for a period of _____ to manage my sleep related breathing disorder (OSA-Obstructive Sleep Apnea) and find it intolerable to use on a regular basis for the following reason(s):

(Please check all that apply)

- ○ Mask Leaks
- ○ An Inability to get the mask to fit properly
- ○ Discomfort caused by the straps and headgear
- ○ Disturbed 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 CPAP apparatus at night
- ○ Other _____

Because of my intolerance/inability to use the CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device.

Signature _____ Date _____