Form 14

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:_____