

**DRS MINTZ & ABBOTT LLC**  
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: \_\_\_\_/\_\_\_\_/\_\_\_\_