CPAP NON COMPLIANT FORM

Patient Name: _____
Date: _____/_____/_____

It has been recommended and/or I have attempted to use CPAP (Continuous Positive Airway Pressure) to manage my diagnosed Obstructive Sleep Apnea condition. I find CPAP intolerable to use on a regular basis due to the following reason(s):

____ The mask leaks
____ I am unable to sleep with the CPAP mask and equipment in place
____ I unconsciously remove the CPAP at night
____ The noise from the device disturbs my sleep
____CPAP does not seem to be effective in reducing/eliminating my symptoms
____ I have tried multiple masks and none are comfortable enough to use
____ I develop sinus/ear/throat/ infections
____ I am claustrophobic
____ My job/ lifestyle prevent nightly use (Army, Reserves, Truck Driver)
____ Other:_____

Because of my intolerance and inability for CPAP to effectively treat my condition, I wish to attempt an alternative therapy. As per the 2006 practice parameters from the American Academy of Sleep Medicine I wish to utilize an oral airway dilator appliance to treat my obstructive sleep apnea.

Patient Signature _____
Date ____/____/_____