MECHANICSBURG FAMILY DENTISTRY

EPWORTH SLEEPINESS SCALE

Patient name:_____ Date:_____

How likely are you to doze off or fall asleep in the following situations:

- **0- No chance**
- **1- Slight chance of dozing**
- **2- Moderate chance of dozing**
- **3- High chance of dozing**

Sitting and reading: ____

Watching TV: ____

Sitting inactive in a public place

(ie: theater/meeting) ____

As a passenger in a car for an

hour without a break: ____

Lying down to rest in the afternoon,

when circumstances permit: ____

Sitting and talking to someone: ____

Sitting quietly after lunch without alcohol: ____

In a car while stopped in traffic for a few minutes: ____

Total Score: ____

A score of 6 or greater indicates a sleep breathing disorder

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Affidavit For Intolerance To CPAP

I have attempted to use the nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reason(s).

- ○ Masks 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 devise 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 any intolerance/ inability to use the CPAP, I wish to have an alternative method of treatment. That form of therapy is an oral appliance therapy (OAT).

Signed : _____ Date: _____