



## **SNORE NO MORE**

### **& Sleep Solutions**

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### **Statement of Sleep Apnea Therapy**

- ☐ **I have mild or moderate sleep apnea and per the American Academy of Sleep Medicine, CMS Guidelines, and insurance policy, I would like to use oral appliance therapy as first line of treatment.**
  - ☐ **I am unable 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 marked reason(s):**
    - 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
    - Latex allergy
    - Claustrophobic associations
    - An unconscious need to remove the CPAP apparatus at night
    - I would like to use Oral Appliance Therapy in conjunction with CPAP Therapy to reduce the CPAP pressure
    - Other:
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**Sign:** \_\_\_\_\_

**Date:** \_\_\_\_\_