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AFFIDAVIT FOR INTOLERANCE TO CPAP

Check the following that apply:

☐ I have **NOT** attempted to use nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons:

☐ Latex allergy

☐ Claustrophobic associations

Other_____

Because of my intolerance/inability to use the CPAP, I wish to have an alternative method of treatment. That form of therapy is oral appliance therapy (OAT).

Print Name: _____

Signature:_____Date: _____

☐ I **HAVE** attempted to use nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons:

☐ 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 my 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 my intolerance/inability to use the CPAP, I wish to have an alternative method of treatment. That form of therapy is oral appliance therapy (OAT).

Print Name: _____

Signature:_____Date: _____