Affidavit for Intolerance to CPAP

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Check the statements and reasons that apply.

I have NOT attempted to use nasal CPAP

☐ I have NOT attempted to use nasal CPAP and find it intolerable for these reasons:

- ☐ Latex allergy
- ☐ Claustrophobic associations
- ☐ An unconscious need to remove the CPAP apparatus at night

Other _____

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

Print name _____ Date _____

Signature _____

I HAVE attempted to use nasal CPAP

☐ I HAVE attempted to use nasal CPAP and find it intolerable for these reasons:

- ☐ Mask leaks
- ☐ An inability to get the mask to fit properly
- ☐ Discomfort or interrupted sleep caused by 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 CPAP, I wish to have an alternative method of treatment. That form of therapy is oral appliance therapy (OAT).

Print name _____ Date _____

Signature _____