7600 West Hwy 29, Suite 9 Georgetown, TX 78628
ph. (512) 930-7645 fax (512) 930-7648

CPAP Intolerance Affidavit

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

___An unconscious need to remove the CPAP apparatus

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

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: _____