KAIROS SLEEP CLINIC

PAP COMPLIANCE, EFFICACY, & SATISFACTION ASSESSMENT

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Please complete this assessment regarding your positive airway pressure (PAP) therapy.

1. Usage Frequency (Compliance)

How many nights per week do you use your PAP device?

☐ 0 nights ☐ 1-2 nights ☐ 3-4 nights ☐ 5-6 nights ☐ Every night

2. Average Nightly Use (Compliance)

On nights you use it, how many hours on average do you wear the PAP mask?

☐ Less than 2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ 6+ hours

3. Daytime Sleepiness (Efficacy)

How much has your daytime sleepiness changed since starting PAP?

☐ Much worse ☐ Slightly worse ☐ No change ☐ Mild improvement ☐ Moderate improvement ☐ Significant improvement

4. Sleep Quality (Efficacy)

How would you rate your overall sleep quality while using PAP?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

5. Mask Fit & Comfort (Satisfaction)

How satisfied are you with the comfort and fit of your PAP mask?

☐ Very dissatisfied ☐ Dissatisfied ☐ Satisfied ☐ Very satisfied

6. Overall Satisfaction (Satisfaction)

What is your overall level of satisfaction with your PAP therapy?

☐ Very dissatisfied ☐ Dissatisfied ☐ Satisfied ☐ Very satisfied

7. PAP Problems & Side Effects (Optional)

Describe any problems with leak, noise, skin irritation, chest discomfort, or other issues:

Patient Signature (Sign or Type Name): _____ **Date:** _____