



## **FCHP Compliance Confirmation Form**

- PAP therapy Days used per week? \_\_\_\_\_
  
- PAP therapy Hours used per night? \_\_\_\_\_
  
- Are you experiencing any of the following problems associated with the use of your PAP?
  - Nasal dryness/congestion
  - Mask discomfort
  - Mask Leaks
  - Claustrophobia
  - Other: \_\_\_\_\_
  
- Have you had any recurrence of symptoms since beginning to use PAP?
  - Excessive Daytime Sleepiness
  - Morning Headaches
  - Inability to concentrate
  - Memory Loss
  - Excessive Snoring
  - Decreased Energy Levels
  - Other: \_\_\_\_\_

Patient Name: \_\_\_\_\_

FCHP ID#: \_\_\_\_\_

Date Questionnaire Completed: \_\_\_\_\_ (must be within 30 days from request)

**\* Compliance is defined as utilizing PAP for 4 or more hours/night;  
5 or more nights/week.**

**ALL SUPPLY ORDER REQUESTS MUST BE ACCOMPANIED BY  
THIS COMPLIANCE CONFIRMATION FORM IF AN OBJECTIVE  
COMPLIANCE REPORT IS UNAVAILABLE**