

## Record of Interventions for Improving Adherence to PAP Therapy

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary/Prefer not to disclose (X)		<input type="checkbox"/> Unknown	

Most Responsible Physician Last Name	Most Responsible Physician First Name
Health Care Professional Last Name	Health Care Professional First Name
Designation	
<b>Intervention Record</b>	
Nasal Congestion? <input type="checkbox"/> Yes <input type="checkbox"/> No If client experiences nasal congestion as a barrier to PAP adherence, complete the following: ▶ Is humidification adequate? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ Was a nasal rinse/nasal steroid spray trialed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Claustrophobia/Anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No If client experiences claustrophobia or anxiety, complete the following: ▶ Gradual Exposure (please see appendix for documentation): ▶ Daytime Mask Habitation? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ Nasal Interface Trial? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pressure Intolerance? <input type="checkbox"/> Yes <input type="checkbox"/> Not applicable ▶ Were ramp settings adjusted? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ Was a pressure relief setting option used? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ Is there a significant mask leak present? <input type="checkbox"/> Yes <input type="checkbox"/> No	
BPAP Habituation Daytime Trials? <input type="checkbox"/> Yes <input type="checkbox"/> Not applicable Patient to complete habituation chart (see appendix)	
Other Interventions: _____ _____ _____ _____	
Has the client/ attempted all the interventions listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the client/ decided to proceed with therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the Most Responsible Physician been made aware of interventions made to date? If yes, please have them sign below:	
Most Responsible Physician <i>(last name)</i>	Most Responsible Physician <i>(first name)</i>
Signature	Date



## APPENDIX

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male		<input type="checkbox"/> Female	
<input type="checkbox"/> Non-binary/Prefer not to disclose (X)		<input type="checkbox"/> Unknown	

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