Clinical Respiratory Assessment

Patient Name:_____ **INITIAL VISIT**

Acct. #:_____ **DOB:**_____ **Height:**_____ **Weight:**_____ **Gender:**_____

Language Spoken: _____ **Language Needs Accomodated:** ☐ **No** ☐ **Yes**

Prescribing Physician:_____ **Primary Physician:**_____

Diagnosis:_____

☐ **Lives alone** ☐ **Lives w/family** ☐ **Other**_____

List Caregivers:_____

Agencies involved in Care:_____

Does patient have history of Occupational exposures/Hazards? ☐ No ☐ Yes _____

_____

Smoking History: Does the patient smoke? ☐ Yes ☐ No ☐ Prior Smoker years_____ packs/day_____

If current smoker, how many cigarettes per day? _____

Is patient exposed to second hand smoke? ☐ No ☐ Yes _____

How motivated is patient to quit smoking? ☐ not motivated ☐ slightly motivated ☐ moderately motivated ☐very motivated ☐ N/A

Alcohol use? ☐ **No** ☐ **Yes** Frequency_____

Social Hx/Habits:_____

History of ED visits and/or Hospitalizations within last year:

Date:_____Reason_____

Date:_____Reason_____

Date:_____Reason_____

Date:_____Reason_____

Allergies:_____

Medication Profile (Rx, Nebulizer, MDI, OTC, Herbal) If MDI, does pt have spacer? ☐ Yes ☐ No

Name	Dosage	Frequency	Route

Patient/caregiver instructed on potential side effects of respiratory medications ☐ Yes ☐ No ☐ N/A

Patient compliant with prescribed respiratory therapy ☐ Yes ☐ No ☐ N/A

Patient seems to have an adequate level of understanding / compliance with medication use? ☐ Yes ☐ No

PMD Dispensed: ☐ Yes ☐ No **Educated** ☐ Patient ☐ Caregiver **Return Demo** ☐ Yes ☐ No

MSI STAFF WILL NOT LOAD THE PILLS INTO THE CUPS, ONLY THE PT/ CAREGIVER HANDLES THE MEDICINES

Completed MedSouth/Philips installation Checklist ☐ Yes ☐ No

Completed Philips Lifeline Medication Dispenser Subscriber Activation Form and Services Agreement ☐ Yes ☐ No

Home Irritants/Triggers: ☐ Home is appropriate ☐ Pets/dander ☐ Dust/dirt ☐ Pests/Vermin ☐ Mold

☐ Cigarette/pipe smoke ☐ Strong scents (cleaners, candles, etc) ☐ Other_____

Patient/Caregiver educated on the potential effects of above Irritants/Triggers: ☐ Yes ☐ No ☐ N/A

Comments_____

Medical Hx: *Pulmonary:* ☐ Asthma ☐ Bronchitis ☐ Bronchiectasis ☐ Cancer(lung) ☐ Colds ☐ COPD

☐ Cystic Fibrosis ☐ Emphysema ☐ Fungal infections ☐ Influenza ☐ Pleurisy ☐ Pneumonia ☐ Pneumothorax

☐ Pneumoconioses ☐ Sinus Infections ☐ Alpha 1 anti-tripsin deficiency ☐ TB ☐ Other_____

☐ Neuromuscular Disorders_____ ☐ Skeletal Abnormalities ☐ Other_____

Cardiovascular: ☐ Angina ☐ Heart Attacks ☐ CHF ☐ Irregular heart beat ☐ CAD ☐ Hypertension ☐ MVP ☐ A-Fib

☐ Diabetes ☐ Obesity ☐ Sleep Apnea ☐ Trauma ☐ Other _____

Past Surgeries:_____

_____

_____

Hearing:☐ Good ☐ Poor ☐Deaf **Aid Use:**☐ Yes ☐ No **Vision:**☐Good ☐ Poor ☐Blind **Corrective Lenses:**☐Yes ☐No

Diet: ☐ Regular ☐ Diabetic ☐ low sodium ☐ other dietary restrictions_____

Meals per day _____ **Appetite** ☐ Good ☐ Fair ☐ Poor **Patient able to prepare their meals?** _____

Weight loss goals?_____

	poor	Slightly unhealthy	average	Healthy	Very healthy
Rate your current Dietary habits:	**1**	**2**	**3**	**4**	**5**

Functional Limitations: ☐ Ambulatory ☐ No restrictions ☐ Non-Ambulatory ☐ With Assist Device ☐ Bedbound

☐ Homebound ☐ Amputee ☐ Paralysis ☐ Vision Deficit ☐ Hearing Deficit ☐ Other_____

Fall Risk Assessment Tool completed: ☐ **Yes**

Daily activities: How far can you walk?_____ **Can you take a bath/shower?** _____

Assistance needed with ADL's?_____

	No Activity	Limited Activity	Moderate Activity	Active	Very Active
What is your baseline daily activity level?	1	2	3	4	5

What are your hobbies?	**Current endurance level (time in minutes) with hobby?**
_____	_____
_____	_____
_____	_____

ADL Goals: What would you like to be able to do that you can't now?

(1)_____

(2) _____

(3)_____

Review of Symptoms: ☐ Anxiety ☐ Depression ☐ Memory loss ☐ Confusion ☐ Insomnia ☐ Headaches ☐ Chills ☐ Fever ☐ Night sweats ☐ Nausea ☐ Vomiting ☐ Loss of appetite ☐ Weight loss (unexplained) ☐ Weight gain ☐ Difficulty chewing/swallowing ☐ Heartburn/Reflux ☐ Fatigue ☐ Weakness ☐ Dizziness ☐ Leg/feet swelling ☐ Loss of consciousness/fainting ☐ Claudication ☐ Arryhthmias/palpitations ☐ Chest pain/pressure

Comments: _____

_____

Frequency of Doctor Visits: approximate total visits in a 3 month period _____

Physician: _____ Normal Frequency of visits: _____

_____ _____

_____ _____

_____ _____

_____ _____

Sleep Habits: hrs/night _____ number of pillows_____ Head of bed raised ☐ Yes ☐ No Snore ☐ Yes ☐ No

Awaken with headaches ☐ Yes ☐ No Do you awaken feeling refreshed ☐ Yes ☐ No Nap during the day ☐ Yes ☐ No

	very poor	below average	average	good	very good
How do you rate the overall quality of your sleep?	**1**	**2**	**3**	**4**	**5**

Vital Signs: RR_____ HR_____ BP_____ Resp. Pattern:_____

Cyanosis: Nail beds ☐ Yes ☐ No Lips ☐ Yes ☐ No **Pedal Edema:** ☐ No ☐ Yes Pitting: +1 +2 +3 +4

Retractions: ☐ None ☐ Mild ☐ Moderate ☐ Severe **Accessory Muscle Use:** ☐ Yes ☐ No

Breath Sounds: ☐ Clear ☐ Crackles ☐ Wheezing ☐ Rhonchi ☐ Diminished ☐ Bilateral

☐ Other: _____

Cough: ☐none ☐occasional ☐frequent ☐strong ☐ weak ☐ dry ☐ productive **Mucus:** ☐ clear ☐ yellow ☐ green ☐bloody ☐ thick ☐ thin ☐ foamy ☐ Other_____Quantity: ☐ large ☐ moderate ☐ small

Mental Status: ☐ Oriented ☐ Disoriented ☐ Anxious ☐ Agitated ☐ Lethargic ☐ Obtunded ☐ Other_____

	none	occasionally	mild	moderate	severe
Mood Swings and/or trouble coping:	**1**	**2**	**3**	**4**	**5**
Overall well being, How do you feel in the:	Very Bad	Bad	OK	Good	Very Good
Morning	**1**	**2**	**3**	**4**	**5**
Afternnon	**1**	**2**	**3**	**4**	**5**
Night	**1**	**2**	**3**	**4**	**5**

Skin Assessment: ☐ Normal ☐ Dry ☐ Warm ☐ Cool ☐ Clammy ☐ Pale ☐ Other_____ **Turgor:** ☐ Normal ☐ Abnormal

Shortness of Breath Score: (1- none, 2-occasionally, 3- mild, 4- moderate, 5- severe)

_____ While eating _____ While sleeping _____ With ambulation/exertion _____ With ADL's

_____At rest _____ While bathing _____ Other: _____

ETC02= _____ (result obtained after _____minutes of monitoring)

Oximetry: RA: at rest _____% with ADL_____% with exercise_____%

With O2: LPM_____/Route_____: at rest_____% with ADL_____% with exercise_____%

Spirometry: PEFR _____ FVC _____ FEV1_____ FEV1/FVC_____

MVV_____ Other _____

Teaching/Learning Ability: ☐ Appropriate ☐ Inappropriate_____

Teaching/Education:

☐ Infection Control of DME and accessories ☐ Importance of good hand/personal hygiene to prevent infections

Fire Safety: ☐ Smoke Detector ☐ Fire Extinguisher ☐ No Smoking signs given to patient/caregiver to post at entrances

☐ No smoking/open flames within 5 feet of oxygen- includes O2 concentrator, tanks, O2 tubing, patient, etc.

☐ Patient/Caregiver educated that Oxygen saturates hair, clothing, etc ☐ Educated on proper use/storage of O2 tanks

☐ Fire Safety Material issued and a fire plan reviewed with patient/caregiver ☐ Other_____

☐Electrical/outlet Safety ☐Emergency Back-Up, Procedures and Plan ☐ Pt/caregiver educated on how to file a complaint

Patient's environment is safe/appropriate for prescribed equipment ☐ Yes ☐ No (If No, see comments below)

Disease Specific Education: ☐ COPD ☐ Asthma ☐ Symptom Management ☐ Smoking Cessation

☐ Exercise ☐ Eating well ☐ Living Well with COPD ☐ Other _____

Education/Re-education of Equipment: ☐ Ventilator ☐ Heated Humidifier ☐ Oxygen concentrator ☐ Oxygen Tanks

☐Nebulizer Compressor ☐ Air Compressor ☐ MDI ☐ Spacer ☐ Suction Pump ☐ Philips Medicine Dispenser (PMD)

☐ Other_____

Welcome Book issued and reviewed with patient/caregiver ☐ Yes ☐ No ☐ Already has one from prior delivery

Advance Directive Obtained ☐ Yes ☐ No (If no, an Advance Directive was given to patient/caregiver ☐ Yes)

Patient/Caregiver understands normal and after hours contact procedures ☐ Yes ☐ No ☐ Re-educated

Problems/Needs Identified:

Goals:

Actions/Interventions:

Recommendations/Comments:

Patient signature _____ Date _____

Patient Representative Signature / Relationship _____ Date _____

Clinician Signature _____ Date _____