Clini-Trak Phone Questionnaire

Patient		**Date**	

Current Equipment and/or Neb Meds:

Oxygen:_____ Other:_____

1. Are you having any difficulties operating our equipment? No Yes, describe?

2. Are you using your equipment per the doctor's orders? Yes No- Why?

3. Are you changing your disposables supplies (eg, CPAP masks, tubing, nebulizers, cannulas) as instructed? Yes No-Why?

4. Has your diagnosis changed including re-hospitalizations? No Yes, describe?

5. Has there been a significant change in your condition? No Yes, describe and complete chart below.

Shortness of Breath	Much Worse		Worse		Same		Better	
Cough	Much Worse		Worse		Same		Better	
Mucus Production	Much Worse		Worse		Same		Better	
Activity Level	Much Worse		Worse		Same		Better	
Daytime Sleepiness	Much Worse		Worse		Same		Better	

6. Has there been any significant change to the home environment or support system (e.g, caregivers)?

7. How many unplanned medical encounters, (e.g., Emergency Room, Hospital Admissions, Physician Office Visits, Urgent Care Clinic visits) did you have in a year before you were provided the Trilogy?

8. Where you prescribed:

a. Oxygen	
b. Neb Meds and/or MDI's	

c. CPAP/BiPAP Therapy	
d. Other	

9. How much money did you pay out of your pocket for these unplanned encounters? _____
10. Please tell me what you experienced? (e.g., Lost your job, Lost your home, Were unable to provide for yourself or your family, Were unable to eat, Unable to participate in activities of daily living, Unable to participate in family, friends, church events, Just taking care of yourself)

11. How did you feel overall, e.g., were you pleased with your life?

12. Since you have received the Trilogy what has changed

a. How many unplanned Medical Encounters have you had	
b. Able to participate in activities of daily living	
c. Able to participate with family, friends and church activities	
d. Able to take care of self	
e. How much money have you paid for your medical care now	
f. Are you pleased with your life now, if not Why	

13. Do you need any supplies sent to you or is there anything else we can do for you?

Additional Comments:

Clini-Trak Completed by:		Date	

Additional Follow Up:

None Required		Home Visit by Clinician		Phone Call by Clinician		Other Action Taken	