

AffloVest Therapy Adherence Assessment Follow-Up Form

Date of Assessment: _____ 7 Days ____ 30 Days ____ 60 Days ____ 180 Days ____

Patient Name: _____ Date Patient Received Vest: _____

Please answer the following questions based on your experience with the AffloVest:

Program and Intensity: _____

Are you still using the AffloVest according to your Doctor's prescription? If no, when did you stop using it?

What is the length of each therapy session? _____

Please rate your response to the following questions since beginning your treatments with the AffloVest System.

Please check the appropriate response: (1 = Strongly disagree 2 = disagree 3 = same 4 = agree 5 = strongly agree)

My breathing has improved 1__ 2__ 3__ 4__ 5__

My secretions have improved 1__ 2__ 3__ 4__ 5__

My sleep has improved 1__ 2__ 3__ 4__ 5__

My treatment regimen has improved 1__ 2__ 3__ 4__ 5__

My activity/energy level has improved 1__ 2__ 3__ 4__ 5__

My quality of life has improved 1__ 2__ 3__ 4__ 5__

I received proper training 1__ 2__ 3__ 4__ 5__

Do you understand the benefits of daily use of your AffloVest? Yes No

Since you began using the AffloVest, have you required treatment with antibiotics or any other medications to treat a respiratory/lung infection? If yes, how many times has this occurred?

Since you began using the AffloVest, have you required hospitalization related to your respiratory condition? If yes, when and where?

Since you began using the AffloVest, have you required a visit to the emergency room or urgent care related to your respiratory condition? If yes, when and where?

Who is your current physician you are seeing for your Respiratory issues? _____

Do you feel you need any additional instruction?

Yes

No

Additional Comments:

Name of person completing survey: _____

Relationship to person: _____

Date form completed: _____

Respiratory Therapist who completed phone assessment: _____

Respiratory Therapist Notes:

Further Recommendations:
