FOLLOW-UP VISIT

Patient Name:_____

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

Initial Date of NIV set-up _____

Prescribing Physician:_____ Primary Physician:_____

Diagnosis:_____

☐ Lives alone ☐ Lives w/family ☐ Other_____

List Caregivers:_____

Agencies involved in Care:_____

ED VISITS/ HOSPITALIZATIONS SINCE LAST VISIT ? ☐ No ☐ Yes (list below)

Date:_____Reason_____

Date:_____Reason_____

MEDICATION CHANGES SINCE LAST VISIT? ☐ No ☐ Yes (list below)

Name	Added / Discontinued	Dosage	Frequency	Route

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

Patient seems to have an adequate level of understanding with PMD? ☐ Yes ☐ No ☐ N/A

SMOKING CESSATION-

How motivated is patient to quit smoking?

☐ not motivated ☐ slightly motivated ☐ moderately motivated ☐ very motivated ☐ N/A

Reduction in smoking? Cigarettes per day: Initial_____ This Visit_____ Percent Reduction _____

Comments:_____

DIET- WEIGHT LOSS

	Initial Score	poor	Slightly unhealthy	average	Healthy	Very healthy
Rate you current Dietary habits:		1	2	3	4	5

Initial stated weight loss goal _____

Weight loss since last visit? Initial weight _____ This Visit _____ Percent reduction_____%

ACTIVITIES OF DAILY LIVING:

How far can you walk? Initial_____ This Visit _____ Percent Improvement _____%

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

Hobbies	Initial Endurance level (min.)	Current Endurance level (min.)	Percent Improvement
			%
			%
			%

Initial ADL Goals: What would you like to be able to do that you can't now? — Improvement since last visit?

(1)_____ _____

(2) _____ _____

(3)_____ _____

Overall well being, How do you feel in the:	Initial Score	Very Bad	Bad	OK	Good	Very Good
Morning		1	2	3	4	5
Afternoon		1	2	3	4	5
Night		1	2	3	4	5

SHORTNESS OF BREATH SCORE: (1- none, 2-occasionally, 3- mild, 4- moderate, 5- severe)

	Initial	This Visit		Initial	This Visit
While eating			With ADL's		
While Sleeping			At Rest		
With ambulation/exertion			While Bathing		
Other_____					

DECREASE IN FREQUENCY OF DOCTOR VISITS? ☐ No ☐ Yes (list below)

Approximate visits in a 3 month period: Initial_____ Current _____ reduction _____%

Change in physician(s)? ☐ No ☐ Yes_____

SLEEP HABITS:

Hours/night: Initial _____ This Visit _____ Percent Improvement_____%

comments:_____

	Initial Score	very poor	below average quality	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_____

	Initial Score	none	occasionally	mild	moderate	severe
Mood Swings and/or trouble coping:		1	2	3	4	5

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: _____

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

ETC02= _____

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

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

Spirometry: FVC _____ FEV1_____ FEV1/FVC_____

MVV_____ Other _____

Teaching/Learning Ability: ☐ Appropriate ☐ Inappropriate_____

Teaching/Education: ☐ Infection Control ☐ Fire Safety ☐ Emergency Back-Up, Procedures and Plan

☐ Electrical/outlet Safety ☐ Emergency Planning/resources ☐ Other_____

Fall within last three months? ☐ Yes (see comment below) ☐ No **Fall Risk Education Provided** ☐ Yes ☐ No ☐ N

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 _____

☐ Other _____

Memory Card Downloaded: ☐ **Yes** ☐ **No** **NIV compliance per download(days with device usage)** _____**%**

Problems/Needs Identified:

Goals:

Actions/Interventions:

Recommendations/Comments:

Patient/Caregiver Signature _____ Date _____

Patient Representative Signature/ Relationship _____ Date _____

Clinician Signature _____ Date _____