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| --- | --- |
| A picture containing text  Description automatically generated | Family name:  Given name(s):  Address:  Date of birth: Sex:  M  F |
| Date of Assessment: ......... / ......... / ......... | |
| Hospital based  Telehealth  Phone  Referrer: ............................................................................... | |
| **Respiratory diagnosis:**  COPD  Bronchiectasis  Interstitial Lung Disease  Asthma  Other......................................  Latest spirometry date (if available) ......... / ......... / .........  FEV1 (actual, % pred) ............................................. FVC (actual, % pred) .............................................  FEV1/FVC (%) ............................ DLCO (% pred) ............................ KCO (% pred) ............................  AWC regime Yes  No  N/A  Current regime: ....................................... Referral to Respiratory OPD Yes  No | |
| **Current medical conditions:**  Cardiac: Yes  No  Diabetes: Yes  No  Hypertension: Yes  No  Mental health: Yes  No  Renal: Yes  No  Circulatory: Yes  No  Incontinence: Yes  No  Neurological: Yes  No  Musculoskeletal: Yes  No  Gastrointestinal: Yes  No  Surgical procedures: Yes  No  Obstructive sleep apnoea: Yes  No  If yes, details: .......................................................................................................  Cancer: Yes  No  If yes, details: .......................................................................................................………………….  Do any of these conditions or any other problems affect, influence or limit your ability to exercise? Yes  No  If yes, cancer type and disease stage: ....................................................................................................................................................................................................  Current medical treatment details:………………………………………………………………………………………………………. | |
| **Medications** (please list or provide list) .....................................................................................................................................  Have you been prescribed any medication to use before / when you exercise? Yes  No  If yes, details: ............................................................................................................................................................................. | |
| **Vaccines:** Current influenza vaccination: Yes  No  Current pneumococcal vaccination: Yes  No | |
| **Respiratory history:** (Exacerbation defined as **respiratory symptoms** requiring the use of **steroids and/or antibiotics**)  *In the last* ***12 months****:* Number of exacerbations: .............. When was your last exacerbation? Date: ......... / ......... / .........  Number of hospitalisations for an exacerbation: .............. Number of ED presentations for an exacerbation: .............. | |
| **Home oxygen:** Yes  No  Prescription: At rest: ........ L/min: ........ hrs/day With exercise: ........ L/min Nocturnal: ........ L/min  Actual use: At rest: ........ L/min: ........ hrs/day With exercise: ........ L/min Nocturnal: ........ L/min | |
| **Previous pulmonary rehab completion:** Yes  No  If yes, details (date, location, reason for non-completion):  .................................................................................................................................................................................................... | |
| **Smoking status:** Current  Never  Previous  Quit date: ......... / ......... / .........  Years smoked ........ No of cigarettes per day ........ Pack year history ........  Offered smoking cessation education/resources? Yes  No  If yes, details ................................................................... | |
| **Falls in the past 6 months:** Yes  No  If yes, details .................................................................................................... | |
| **Indigenous status:** Aboriginal  Torres Strait Islander  Both  Neither | |
| **Social history:**  Work status Full time  Part time  Unemployed  Retired  Lives: alone  or with: ............................ Support person name/details: ............................................................................. | |
| **Do you have a current Action Plan:** Yes  copy taken and filed in chart Date completed: ......... / ......... / ......... No  If yes, patient confident in following Action Plan: Yes  No  N/A  Do you have rescue medication or prescription available (if relevant to Action Plan): Yes  No  If no to any, refer to GP for Action Plan review. Blank Action Plan given to patient to take to GP | |
| **Inhaler technique** Checked today or in the last 12 months Yes  No  N/A  OR Plan to check during program | |
| **Nutrition – Malnutrition screening assessment (MST)** Have you lost weight recently without trying?  *No =* 0 *Unsure =* 2 *Yes, how much (kg):* 1-5 = 1 6-10 = 2 11-15 = 3 >15 = 4 Unsure = 2  Have you been eating poorly because of decreased appetite? *No =* 0 *Yes =* 1  Total MST score: …....................... refer to Dietician if MST ≥ 2 | |
| **Current patient goals:** …..........................................................................................................................................................  …................................................................................................................................................................................................. | |
| **Pre course exercise level:** Number of days/week: …............................... Duration: …...............................  Usual hours of exercise per week < 2 hours  2 – 4 hours  > 4 | |
| **St George’s Respiratory Questionnaire (SGRQ)** Yes  No | |
| **Modified MRC Dyspnoea Scale (mMRC)** – one answer for an average day in the last week  0  I only get breathless with strenuous exertion  1  I get breathless hurrying on the level or walking up a slight hill  2  I walk slower on the flat than most people of my age because of breathing difficulty, or have to stop for  breathing walking at my own pace on level ground  3  I need to stop to get my breath walking on the level for 100m or after a few minutes at my own pace on level ground  4  I am too breathless to leave the house or become breathless when dressing or undressing | |