|  |  |
| --- | --- |
| 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/minActual 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 week0 [ ]  I only get breathless with strenuous exertion 1 [ ]  I get breathless hurrying on the level or walking up a slight hill2 [ ]  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 ground3 [ ]  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 ground4 [ ]  I am too breathless to leave the house or become breathless when dressing or undressing |