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Respiratory Assessment

PEL/VIP 800-779-4231

PAYOR: ☐ Managed Care ☐ MED ☐MC ☐ INS ☐ PVT ☐ OTHER
PROGRAM: ☐ PNE High / Low ☐CHF High / Low ☐COPD High / Low ☐ FACILITY REQUEST
FORM: ☐ INITIAL RESPIRATORY ASSESMENT

Date: **TimeStart:** **Time End:** **Admit//readmit date:** **Date of Birth:**

Resident Name: Room: Sex: ☐M ☐ F	Primary Respiratory Diagnosis: Current Respiratory Orders Reviewed ☐**Y**☐**N** Recommendations ☐**Y**☐**N**

Pulse:	☐ Strong ☐ Weak **SKIN/COLOR**: ☐ Normal ☐ Pale ☐ Cyanotic ☐ Digital Clubbing ☐Blanching ☐ Edema:	
Spo2%: _____**LNC** ☐ Rest ☐ Exer	**BREATH SOUNDS**	☐ Clear ☐ Diminished ☐ Absent ☐ Wheezes ☐ Crackles ☐ Rhonchi ☐ Rales ☐ Bilateral ☐ R ☐ Lower ☐ Middle ☐ Upper - ☐ L ☐ Lower ☐ Upper
RR:	**QUALITY OF RESP:** ☐ Easy ☐ Deep ☐ Shallow ☐ Labored **Rhythm**: ☐ Reg ☐ Irregular **Symmetry**: ☐ Even ☐ Uneven	
BP:	**Primary Care Physician:**_____	
HYDRATION: ☐Adequate ☐Inadequate	**SECRETIONS/COUGH**:☐ None ☐ Weak ☐ Strong ☐ Dry ☐ Nonproductive Sputum frequency ☐ Increase ☐Decrease ☐ Small ☐ Mod ☐ Large ☐ White ☐ Yellow ☐ Green ☐ Grey ☐ Brown ☐ Thick ☐ Thin ☐ Frothy ☐ Odor	
TEMP:	**ORTHOPNEA:** ☐Y☐N **ASSESSMENT:**	
WBC:	**DYSPNEA:** ☐Words ☐Phrases ☐Sentences **PERIPHERAL EDEMA:** ☐N/A +_____☐Left Leg ☐Right Leg ☐Belly	
HGB:	**SPECIAL CONSIDERATIONS:** ☐Aspiration Precautions ☐Head of Bed Elevated 30°-45° ☐Other:_____	
RBC:		

***Education:**
☐Hand washing ☐Oral care/hygiene ☐Hydration ☐ Smoking Cessation ☐Importance of Reporting of Symptoms
☐Fluid/Sodium Restrictions ☐Nutrition
☐Deep Breathing/Incentive Spirometry
☐Effective Cough/Splinting/Airway Clearance
☐Signs and Symptoms of Pneumonia
☐Signs and Symptoms of CHF
☐Signs/Symptoms of COPD Exacerbation
☐COPD-Disease Education ☐Breathing Exercises (PLB)
☐Respiratory Medications ☐Energy Conservation
☐Other_____

TRACH/STOMA: ☐ Dry ☐ Moist ☐ Reddened
Size:_____**Model/Man:**_____
☐ Tracheostomy ☐ Speaking Valve ☐ Capping
Style : ☐ Cuffed ☐ Uncuffed ☐ Long
Inner Cannula: ☐Disp ☐Std ☐Perm ☐Fen ☐None
EMERGENCY SUPPLIES: ☐n/a ☐Man Resuscitator ☐ Extra Trach Tube ☐Down Size Trach
(Only Fill in Box if Trach/Stoma Present)

Respiratory Meds/Modalities/Procedures	FRQ	Started	Compliant
☐ _____	_____	___-___-____	☐**Y**☐**N**
☐ _____	_____	___-___-____	☐**Y**☐**N**
☐ _____	_____	___-___-____	☐**Y**☐**N**
☐ _____	_____	___-___-____	☐**Y**☐**N**
☐ O2_____	_____	___-___-____	☐**Y**☐**N**
☐PAP Therapy_____	_____	___-___-____	☐**Y**☐**N**
☐Vest Therapy_____	_____	___-___-____	☐**Y**☐**N**
☐Acapella_____	_____	___-___-____	☐**Y**☐**N**
☐Incentive Spirometry_____	_____	___-___-____	☐**Y**☐**N**
☐Oral Care_____	_____	___-___-____	☐**Y**☐**N**
☐Hand Washing_____	_____	___-___-____	☐**Y**☐**N**
☐Patient Weights_____	_____	___-___-____	☐**Y**☐**N**
Admit Wt:_____ **Last WT:**_____ **Current WT:**_____			
☐Diuretics_____	_____	___-___-____	☐**Y**☐**N**
☐Other: _____	_____	___-___-____	☐**Y**☐**N**

Recommendations/Interventions/Education

Notes:

* Recommendations Reviewed with Nurse on Duty: SIGNATURE OF RT _____