CHEST PT 101, LLC
Hands on Therapy
www.CPT101.com

EXACERBATION ASSESSMENT

Office Locations
North Carolina
Florida & Texas
Phone: 833-327-8101
Fax: 855-436-5302

PATIENT INFORMATION

Patient's name:	Date of Birth:

WHAT WAS YOUR ASSESSMENT REGARDING PULMONARY EXACERBATION AT THIS VISIT?

❑ Absent ❑ Mild exacerbation ❑ Moderate exacerbation ❑ Severe exacerbation ❑ Don't know/unable to answer

PRESCRIBED EXACERBATION TREATMENT

If you determined that an exacerbation was present, please select the treatment course already prescribed to treat the exacerbation:

❑ Increased airway clearance, exercise, and/or bronchodilators
❑ Oral NON-quinolone antibiotic (e.g. azithromycin, Bactrim, Augmentin, etc.)
❑ Oral quinolone antibiotic (e.g. ciprofloxacin (Cipro), levofloxacin)
❑ Inhaled antibiotic
❑ Inhaled antibiotic PLUS Oral NON-quinolone antibiotic
❑ None of the above

If none of the above, then specify: _____ (Note: If treated with hospital or home IV antibiotics)

CONSULTATIONS WITH CARE TEAM MEMBERS

❑ Patient consulted with a Social Worker at this visit
❑ Patient was seen by a Dietitian/Nutritionist at this visit
❑ Patient was seen by a Physical therapist at this visit
❑ Patient was seen by a Respiratory therapist at this visit
❑ Patient consulted with a Pharmacist at this visit

Notes: _____
_____
_____

THERAPIST INFORMATION

Therapist Name (please print):	Evaluation Date:
Respiratory Therapist Signature	Submission Date

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Please fax this completed form to: 855-436-5302