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

MONTHLY / QUARTERLY EVALUATION

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

THERAPIST INFORMATION

Therapist Name (please print):

Evaluation Date:

PATIENT INFORMATION

Patient's name:

Date of Birth:

Patient/Family reported FEV1 _____

Approximate Date _____

❑ Increase
❑ Decrease
❑ Stable

Last Hospital Admission _____

Last home IV antibiotic treatment _____

Sputum Description
❑ Reported
❑ Observed

❑ Thick
❑ Thin
❑ Clear
❑ Yellow

❑ Green
❑ Brown
❑ Red

❑ Increase
❑ Decrease
❑ Stable

Change
❑ Yes
❑ No

Weight _____
❑ PT/Family Reported
❑ Measured

Median SPO2 _____
Median HR _____
Median RR _____

Patient Breath Sound
❑ Rhonchi/Sonorous wheeze
❑ Crackles/Rales
❑ Sibilant wheezes
❑ Stridor
❑ Pleural friction rub

Bacterial Culture done?
❑ Yes ❑ No
Date of Culture:
_____

Culture Results:
❑ Microorganisms
❑ Normal flora

Check for each:
❑ Burkholderia species
❑ Mycobacterial species
❑ Klebsiella species
❑ Fungal/Yeast
❑ Staphylococcus aureus: MRSA, MSSA
❑ Pseudomonas aeruginosa
❑ Haemophilius influenzae
❑ Enterobacter species
❑ Other _____

Patient/Family Respiratory Goals

❑ I want to Clear mucus/secretions
❑ I want to Prevent/decrease exacerbations
❑ I want to Increase respiratory adherence and education of treatments
❑ I want to Increase activities of daily living (ADL)
❑ Other (Please describe)

Care Plan

❑ Continue CPT as ordered
❑ Request increase of CPT
❑ Educate patient/family on how to get the most from ACT and medication routine
❑ Other (Please describe)

Therapist notes:
Current order: CPT
_____ times/day
_____ times/week

❑ Patient responding well to therapy
❑ Patient is compliant to therapy
❑ Observed and reported
❑ Decreased coughing
❑ Decreased shortness of breath

MD plan or specific goal for patient/family:

Respiratory Therapist Signature _____

Submission Date _____

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CFCOC Cystic Fibrosis CONTINUITY OF CARE

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