MAYARI ALL CARE CORP.
HOME HEALTH AGENCY

RESPIRATORY THERAPY VISIT NOTE

Patient Medical Record No. checked? ☐
ID checked? ☐ Name checked? ☐

DATE OF SERVICE ___/___/___
TIME IN _____ OUT _____

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) _____

TYPE OF VISIT
☐ Regular visit
☐ Revisit and Supervisory Visit
☐ Other (specify) _____
SOC DATE ___/___/___

TREATMENT DIAGNOSIS/PROBLEM/OUTCOMES _____

Patient Position: ☐ Fowler ☐ Semifowler ☐ Supine ☐ Sitting ☐ Trendenberg ☐ Other: _____
PRE HR _____ RR _____ **Breath Sounds** ☐ Clear ☐ Rhonchi ☐ Rales ☐ Wheezes ☐ Stridor ☐ Dim. Location _____
POST HR _____ RR _____ **Breath Sounds** ☐ Clear ☐ Rhonchi ☐ Rales ☐ Wheezes ☐ Stridor ☐ Dim. Location _____

RESPIRATORY THERAPY INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X")

☐	Equipment Recommendation:	☐	OXYGEN Therapy FiO2/LPM _____	☐	Blow-by
☐	Establish respiratory rehab. program	☐	OXYGEN Walk	☐	Speech dysphagia instruction program
☐	Establish home maintenance program	☐	OXYGEN Precautions, Fire Prevention	☐	SAN / Aerosol Meds:
	☐ Copy given to patient	☐	I.S. Treatment frequency:		
	☐ Copy attached to chart	☐	Fluid diet recommendations	☐	Teach/Develop respiratory skills
☐	Patient/Family education/training	☐	Mask	☐	Trach. instruction and care
☐	BIPAP: IPAP ____ cm H2O EPAP ____ cm H2O	☐	Therapy to relief respiratory distress,	☐	Patient Toleration: ☐ Well ☐ Fair ☐ Poor
☐	MDI/DPI	☐	frequency, (describe):	☐	Adverse Reaction ☐ No ☐ Yes Comments:
☐	CPT	☐	Mouthpiece, specify:	☐	
☐	CPAP/EZPAP _____ cm H2O	☐		☐	Other:

Cough ☐ Productive ☐ Non-Prod. Sputum Consistency ☐ Thick ☐ Thin **Sputum Amt.** ☐ Small ☐ Moderate ☐ Large
Sputum Color: ☐ White/Clear ☐ Yellow ☐ Beige ☐ Green ☐ Red ☐ Other _____
Vital Signs: Temp: _____ B/P: _____ Pulse: _____ Resp: _____

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES _____

EVALUATION AND PATIENT/CAREGIVER RESPONSE _____

CARE PLAN: ☐ Reviewed/Revised with patient involvement.
If revised, specify _____
☐ Outcome/instruction achieved (describe) _____
☐ PRN order obtained
APPROXIMATE NEXT VISIT DATE: ___/___/___
PLAN FOR NEXT VISIT _____

DISCHARGE DISCUSSED WITH: ☐ Patient/Family
☐ Care Manager ☐ Physician ☐ Other (specify) _____
BILLABLE SUPPLIES RECORDED? ☐ N/A ☐ Yes (specify) _____

CARE COORDINATION: ☐ Physician ☐ PT ☐ OT ☐ ST ☐ MSW
☐ SN ☐ Other (specify) _____

SUPERVISORY VISIT (Complete if applicable)

☐ RT Assistant ☐ Aide / ☐ Present ☐ Not present
SUPERVISORY VISIT ☐ Scheduled ☐ Unscheduled
OBSERVATION OF _____

TEACHING /TRAINING OF _____

PATIENT/FAMILY FEEDBACK ON SERVICES/CARE
(specify) _____

NEXT SCHEDULED SUPERVISORY VISIT ___/___/___
CARE PLAN UPDATED? ☐ No ☐ Yes (specify) _____

If RT assistant/aide **not present,** specify date he/she was contacted regarding updated care plan: ___/___/___

SIGNATURES/DATES

Complete TIME OUT (above) prior to signing below.

Therapist Full Name

X _____ ___/___/___
Therapist (signature/title) *Date*

PART 1 - Clinical Record **PART 2 - Therapist**

PATIENT NAME - Last, First, Middle Initial | ID#

SALUD HOME CARE, INC.

RESPIRATORY THERAPY EVALUATION

DATE OF SERVICE ____/____/____
TIME IN _____ OUT _____

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness
❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ❑ Medical restrictions
❑ Other (specify) _____

TYPE OF EVALUATION
❑ **Initial** ❑ **Interim** ❑ **Final**
SOC DATE ____/____/____
(If Initial Evaluation, complete Respiratory Therapy Care Plan)

ORDERS FOR EVALUATION ONLY? ❑ Yes ❑ No If no, orders are _____

PERTINENT BACKGROUND INFORMATION

MEDICAL DX/TREATMENT DX _____
ONSET ____/____/____
MEDICAL PRECAUTIONS _____
PRIOR LEVEL OF RESPIRATORY STATUS _____
USING: MASK, MDI/DPI, CPT, CRAP/EZR|PAP (describe) _____
DESCRIBE PERTINENT RESPIRATORY HISTORY AND/OR PREVIOUS THERAPY PROVIDED _____
SOB / Dyspnea (describe) _____ Impact on therapy care plan? ❑ Yes ❑ **No**

SAFE RESPIRATORY EVALUATION? ❑ No ❑ Yes; specify date, (describe): _____
OXYGEN / SAN THERAPY? ❑ No ❑ Yes; specify date, (describe): _____
Oxygen/Fire precaution, label in place? ❑ Yes ❑ **No**
CURRENT LIQUID/FLUID DIET: _____
LIQUIDS: ❑ Thin ❑ Thickened (Specify) _____ ❑ Smoker (Frequency/Specify) _____

RESPIRATORY EFFORT EVALUATION

❑ 4- WFL (within functional limits) ❑ 3 - Mild impairment ❑ 2 - Moderate impairment ❑ 1 - Severe impairment ❑ 0 - Not Evaluated/not test

	FUNCTION EVALUATED	Mark 'x'	COMMENTS
COGNITION	Orientation (Person/Place/Time)		
	Attention span		
	Short-term memory		
	Long-term memory		
	Judgment		
	Problem solving		
	Organization		
	Other:		
SPEECH/VOICE	Oral/facial exam		
	Articulation		
	Prosody		
	Voice / Respiration		
	Speech intelligibility		
	Other:		
BREAST SOUNDS	Clear		
	❑ Rhonchi ❑ Rales		
	Wheezes		
	Stridor		
	Dim. Location:		
	Other:		

	FUNCTION EVALUATED	Mark 'x'	COMMENTS
VERBAL EXPRESSION	Augmentative methods		
	Naming		
	Appropriate Yes / No		
	Complex sentences		
	Affected by respiratory problem		
COUGH	Productive		
	❑ Frequent Sputum ❑ Not frequent		
	Non Productive		
	Frequent Coughing episodes		
	Conversation affected by coughing		
	Speech affected by coughing episodes		
SPUTUM	Consistency: ❑ Thick ❑ Thin		
	Amount of sputum:		
	❑ Small ❑ Moderate ❑ Large		
	Sputum Color:		
	White/Clear		
	Yellow		
	Beige		
	Green		
	Red/Sanguineous		
	Other, explain:		

REFERRAL FOR: ❑ Oxygen ❑ Oxygen walk ❑ Swallowing/Speech problems ❑ Other (Specify) _____

Complete TIME OUT (above) prior to signing below.
THERAPIST SIGNATURE/TITLE _____ DATE ____/____/____

PART 1 - Clinical Record **PART 2 - Therapist**

PATIENT NAME - Last, First, Middle Initial | ID#

SALUD HOME CARE

RESPIRATORY THERAPY CARE PLAN

SOC DATE ____/____/____

DIAGNOSIS _____ ONSET ____/____/____

ANALYSIS OF EVALUATION/RESPIRATORY EFFORT _____

_____

_____

_____

❑ Physician orders obtained. Patient/Caregiver aware and agreeable to POC: ❑ Yes ❑ No (explain): _____

❑ Physician orders needed. Follow organization procedure for obtaining verbal orders and completing the 485/POC or submitting supplemental orders for physician signature.

If applicable, portion of Plan of Care assigned to a RTA was discussed, explained to the RTA: ❑ Yes ❑ No ❑ N/A

Locator #22 PATIENT DESIRED OUTCOMES/GOALS	SHORT TERM OUTCOMES/GOALS Time Frame	LONG TERM OUTCOMES/GOALS Time Frame
	❑ Return to pre-illness level of function within _____ weeks. ❑ Patient will meet maximum rehab potential within _____ weeks. ❑ Other:	

PLAN OF CARE (Mark all applicable with an "X".) Locator #21

	Evaluation		OXYGEN Therapy		Blow-by
	Establish respiratory rehab. program		OXYGEN Walk		Speech dysphagia instruction program
	Establish home maintenance program		OXYGEN Precautions, Fire Prevention		SAN / Aerosol Meds:
	❑ Copy given to patient		I.S. Treatment frequency:		
	❑ Copy attached to chart		Fluid diet recommendations		Teach/Develop respiratory skills
	Patient/Family education/training		Mask		Trach. instruction and care
	Check Breast Sound PRE/POST Tx		Therapy to relief respiratory distress, frequency, (describe):		Other:
	MDI/DPI				
	CPT		Mouthpiece, specify:		
	CPAP/EZPAP				

FREQUENCY AND DURATION _____ REHAB POTENTIAL ❑ Good ❑ Fair ❑ Poor

EQUIPMENT RECOMMENDATIONS _____

SAFETY ISSUES/INSTRUCTION/EDUCATION _____

_____

COMMENTS/ADDITIONAL INFORMATION _____

_____

_____

PATIENT/CAREGIVER RESPONSE TO PLAN OF CARE _____

_____

_____

DISCHARGE PLAN DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) _____

CARE COORDINATION: ❑ Physician ❑ PT ❑ OT ❑ ST ❑ MSW ❑ SN ❑ Other (specify) _____

APPROXIMATE NEXT VISIT DATE ____/____/____

PLAN FOR NEXT VISIT _____

_____

_____

PLAN DEVELOPED BY (signature/title/date) _____ ____/____/____

CARE PLAN REVIEW

DATE	REVIEWED/REVISED BY (signature/title)	COMMENTS

PART 1 - Clinical Record **PART 2 - Therapist**

PATIENT NAME - Last, First, Middle Initial	ID#

MAYARI ALL CARE CORP.
HOME HEALTH AGENCY

M.R.#_____

RESPIRATORY THERAPY DISCHARGE/TRANSFER SUMMARY

PATIENT NAME _____

Admission Date: _____/_____/_____
Discharge Date: _____/_____/_____
Date of Last Billable Visit: _____/_____/_____
Diagnosis (Primary) _____

DR. _____
Address: _____

Tel. No. (_____)

SERVICES RENDERED: Total # of actual visits

RN _____ HHA _____
PT _____ OT/ST _____
MSW _____ Other _____
RT _____ _____

REASON FOR DISCHARGE _____

☐ Partial - still receiving services of RN, PT, ST, OT, HHA

☐ Complete

CONDITION ON DISCHARGE:

___ Stable ___ Improved
___ Unstable ___ Deceased
___ Other: _____

DISPOSITION OF THE PATIENT:

___ Able to care for self
___ Institutionalized
___ Family to assist
___ Homemaker to assist ___ Deceased
___ Other: _____

RT/RN/Agency contacted physician on _____/_____/_____ and discharged is approved.

SUMMARIES:

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED:

___ Verbalizes knowledge of medications, side effects, precautionary measures, diet, fluids, disease process, treatment program, s/s necessitating medical attention.
___ Return to previous lifestyle with modification within disease limitations.
___ Independence in self care within disease limitation
___ Home free of hazards using proper safety
___ Presenting symptoms absent and/or controlled by appropriate intervention
___ Maximum potential attained within home setting.

On Discharge:	VITAL SIGNS	Vital Signs Range
_____	TEMPERATURE	_____ TO _____
_____	PULSE	_____ TO _____
_____	RESPIRATION	_____ TO _____
_____/_____	BLOOD PRESSURE	____/____ TO ____/____

PATIENT/FAMILY INSTRUCTED IN:

☐ Respiratory Care
☐ SAN Administration
☐ Disease Process
☐ S/S of complications
☐ Action/Side effects of Medications
☐ Oxygen Therapy/Care
☐ Respiratory Management
☐ Diet/Fluid Intake
☐ Tracheostomy Care
☐ Safety Factors
☐ Respiratory Equipments
☐ Activity Restrictions
☐ Administration respiratory rehab program
☐ Administration of Inhalation Rx
☐ Use of mask, therapy to relief respiratory distress
☐ Dysphagia instructions program
☐ S/S Complications/Infection

Patient/Family response and adherence to teachings: ____ Good ____ Fair ____ Poor ____ Repetitive teaching required
Goals Met: ____ Yes ____ No If No, explain _____
Patient/Family Goals Met: ____ Yes ____ No If No, explain _____

Employee's Signature: _____ Title _____ Date _____/_____/_____