Pulmonary Rehabilitation Assessment Form

Name:	Date of Assessment:
DOB:	Hospital No:
Address:	Medical Card No:
	Tel No:
	Mobile No:
	Consultant:
	GP:
Respiratory Diagnosis:	
Other/Past Medical History:	**Social History** *Occupation:* *Mobility:* *Transportation:*
Medications:	**Baseline Respiratory Function:** *Mob Distance* *Stairs* *Uphill* *Orthopnoea* *Cough* *Sputum* *Wheeze* *Stress Incontinence* *Other*
Home O2: Y N L/min	**Portable O2** Y N L/min
BiPAP: Y N Make:	IPAP: EPAP:
Home Nebs: Y N	
Smoking History: Y N Ex	Pack Years
BMI:	**BORG:**
HEART RATE:	**SaO2:**
CXR Report:	