Bronchiectasis Toolbox

Bronchiectasis Assessment Form

(Patient label)

Assessment date:_____ Pt No:_____

Name:_____ DOB:_____

Address:_____

Ph:_____ Mob:_____

Referred by:_____

GP name:_____GP Ph:_____

Approx. date diagnosis:_____

Approx. date when started symptoms:_____

Past history (respiratory):_____

_____

Smoker: Y / N Year stopped smoking:_____

Daily cough: Y / N Irritable / productive / effective / ineffective

Sputum quantity:_____ Colour:_____

Haemoptysis:_____

Ease of expectoration:_____

Infections over past 12 months:_____

Co-morbiditites:_____

Cardiac history:_____

Lung surgery:_____

GOR: Yes / No Treatment:_____

Sinusitis: Yes / No Treatment:_____

HRCT date:_____HRCT findings:_____

LFT's date:_____LFT's results:_____

Auscultation:_____

SpO2%:_____ HR:_____ RR:_____

Breathing pattern: Nose / Mouth Upper chest / lower chest

Medications respiratory:_____

_____

Device types: MDI Spacer Accuhaler Turbuhaler Nebuliser

Other:_____

Medications other:_____

_____

Oxygen therapy:_____

CPAP: Y / N Mask type:_____ Humidified: Y / N

Urinary incontinence: Y / N Treatment:_____

Hydration:_____

Owns a nebuliser? Yes / No Type:_____

Current AC routine:_____

Past physio treatment:_____

Gait aids:_____

Exercise:_____

_____

_____

Exercise limitations:_____

_____

Comments:_____

_____

_____

Management plan:_____

_____

_____

Review:_____

Referral letter to:_____