

Respiratory Assessment Tool

Last Name _____ First Name _____ Date _____

Medicaid ID# _____ Date of Birth _____

Current Status _____

Pertinent Medical History _____

Height _____ Weight _____ IV _____ Average Fluid Intake per 24 Hours _____ ccs
 Diet Order _____ Signs of Dehydration Yes No

Intubations Date: _____ Emergency? Yes No (Oral Nasal)

Tracheotomy Date: _____

Tracheotomy Tube Type: _____ Size: _____
 Cuffed: _____ Inflated Deflated
 Cuff-less: _____

Is Trach Being Plugged? Yes No Duration: _____

Breath Sounds: _____

Secretions: Oral _____ Tracheal _____

Amount _____ Consistency _____

Color _____ Odor _____

Comments _____

Procedure	Most Recent Date	Results
Chest X-Ray		
Bronchoscopy		
Laryngoscopy		
Sputum Culture		
ABG's		

Is client MRSA colonized? Yes No

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Is VRE (Vancomycin Resistant E.Coli) diagnosed? Yes No

Ventilator

Type of Ventilator _____ Date Artificial Ventilation Started _____

Ventilator Mode	Ventilator Settings	Ventilator Weaning
<i>Control</i>	<i>Tidal Volume</i>	<i>Method</i>
<i>A/C</i>	<i>Rate</i>	<i>SIMV</i>
<i>SIMV</i>	<i>PEEP</i>	<i>CPAP</i>
<i>CPAP</i>	<i>FIO2</i>	<i>PS</i>
<i>PS</i>		<i>T-Piece</i>
		<i>Length of Weaning Trial:</i>
		<i>Tolerance to Weaning</i>

Spontaneous Ventilation: (Date) _____ Spontaneous Weaning Parameters: (Date) _____

VT _____ (5-8 cc/Kg) *RR* _____ (8-20/min)

VC _____ (2xVT) *NIF* _____ (min acceptable -20cc H2O to 80cc H2O)

MV _____ (8-15 L/min)

Supplemental Oxygen

FIO2: _____ *LPM* _____ *Delivery Method*: Trach Collar TT02 Nasal Cannula

Respiratory Therapy

Type: _____

Meds: _____

Frequency: _____

Other: _____

Vital Signs: T _____ P _____ R _____ B/P _____ Pulse Ox _____

**** THE FOLLOWING INFORMATION IS REQUIRED FOR DDM TO COMPLETE THE ASSESSMENT****

Estimated number of Respiratory therapy hours needed: _____

Estimated number of Skilled Nursing hours needed: _____

Prognosis: _____

Signature of Assessor: _____ Date: _____