

Institution:

[Empty box for Institution name]

Reserved for bar code

Department:

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Discharge planning tool

Admission Dx: \_\_\_\_\_ Admission Date: YYYY / MM / DD

**Dx COPD**  Yes (FEV<sub>1</sub> < 80% & FEV<sub>1</sub>/FVC < 0.7)  To confirm

1<sup>st</sup> spirometry (<48 hrs) : YYYY / MM / DD Last (at discharge) : YYYY / MM / DD

FEV<sub>1</sub> \_\_\_\_ % pred; FEV<sub>1</sub>/FVC \_\_\_\_ (absolute value) FEV<sub>1</sub> \_\_\_\_ % pred; FEV<sub>1</sub>/FVC \_\_\_\_ (absolute value)

Other Dx: \_\_\_\_\_  Smoker  Non smoker  
 quit, since \_\_\_\_\_

Action plan (self-prescription)  Yes  No  Unknown  
If Yes, started before admission  Yes  No  Unknown

Self-management skills - Summary of skills AT DISCHARGE	Yes	No	To follow-up	To assess
Understands well his/her medication				
Good inhalation technique				
Good pursed-lip breathing				
Good body position to reduce shortness of breath				
Good cough technique				
Capable of defining his/her baseline				
Identifies signs of deterioration				
Knows available resources in case of worsening				

		Discharge date YYYY / MM / DD	
Referral for COPD Follow-up <input type="checkbox"/> N/A <input type="checkbox"/> Refuses <input type="checkbox"/> Unknown	<input type="checkbox"/> CLSC/CHC	CLSC/CHC or <input type="checkbox"/> SRSAD (Mtl) or respiratory home care services	
Dyspnea (MRC) at discharge <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5		
≥ 4 exacerbations (last 12 months) <input type="checkbox"/> No	<input type="checkbox"/> Yes		
≥ 3 hospitalizations or ER visits (last 12 months) <input type="checkbox"/> No	<input type="checkbox"/> Yes		
During hospitalization saturation at rest often fluctuated at < 90% <input type="checkbox"/> No	<input type="checkbox"/> Yes		
Respiratory equipment (O2/neb) <input type="checkbox"/> Hypercapnia <input type="checkbox"/> Sleep apnea <input type="checkbox"/> No	<input type="checkbox"/> Yes		
Pulmonary rehabilitation reference <input type="checkbox"/> Yes <input type="checkbox"/> Ant If No : <input type="checkbox"/> Not eligible <input type="checkbox"/> Refuses <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____			
If smoker ► motivated to stop - <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Smoking cessation reference <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Follow up appointment (2-4 weeks) Physician : _____			
Outside prescription and explanations given- <input type="checkbox"/> Ventolin/Bricanyl <input type="checkbox"/> Atrovent <input type="checkbox"/> Serevent/Oxeze <input type="checkbox"/> Flovent/Pulmicort <input type="checkbox"/> Advair/Symbicort <input type="checkbox"/> Spiriva <input type="checkbox"/> Nicotine replacement therapy <input type="checkbox"/> Aerochamber			
Comments : _____			
Name in block letters	Signature	Initials	Date: YYYY/MM/DD