

CYSTIC FIBROSIS with PULMONARY EXACERBATION

	PHASE 1: ADMIT & INITIATE THERAPY	PHASE 2: THERAPY (INPT OR HOME)	PHASE 3: DC THERAPY																
<p>CRITERIA FOR PATIENT PLACEMENT</p>	<p>CRITERIA FOR INIATING TREATMENT OF CF PULMONARY EXACERBATION *</p> <p><i>Presence of at least 3 of the following:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Decrease FEV₁ of >10% from baseline <input type="checkbox"/> Increased Cough <input type="checkbox"/> Increased / change in sputum <input type="checkbox"/> Fever, >38°C >4 hrs in 24 hr period, >1 time in last week <input type="checkbox"/> Weight loss > 5% of body weight <input type="checkbox"/> School/work absenteeism in last week <input type="checkbox"/> Increased resp rate or WOB <input type="checkbox"/> New finding on chest exam <input type="checkbox"/> Decreased exercise tolerance <input type="checkbox"/> Decrease in SaO₂ >10% from baseline <input type="checkbox"/> New finding(s) on Chest X-ray <p>Other clinical findings:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Attach CF Clinic Flow Sheet <p><i>* As published in Clinical Practice Guidelines for Cystic Fibrosis. CF Foundation, 1997, Appendix VIII, Table 7</i></p>	<p>CRITERIA FOR POSSIBLE TRANSITION TO HOME FOR COMPLETION OF PULM EXACERBATION TREATMENT:</p> <p><i>Patient must meet all of the following, AND be assessed as clinically safe for transfer to home care:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Baseline FEV₁ > 40% <input type="checkbox"/> Prior clinical response to inpt IV antibiotic treatment <input type="checkbox"/> Stable IV access <input type="checkbox"/> Medically sophisticated caretakers at home <input type="checkbox"/> Stable social support services <input type="checkbox"/> Access to interval clinical assessment, including PFT <input type="checkbox"/> No new onset of CF complications <input type="checkbox"/> No additional complex medical problems <input type="checkbox"/> Able to take maintenance enteral or PO fluids <input type="checkbox"/> Established therapeutic level of Tobramycin <input type="checkbox"/> Safe plan for transport home <p>Other barriers to home therapy:</p>	<p>CRITERIA FOR DISCONTINUATION OF THERAPY FOR PULM EXACERBATION:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Improvement & Plateau of PFT (near baseline) <input type="checkbox"/> Improved nutritional status <input type="checkbox"/> Stabilization of co-morbid condition(s) <input type="checkbox"/> Increased activity tolerance <input type="checkbox"/> Decreased cough & sputum production <p>Other requirements for discontinuation of therapy:</p>																
<p>HEALTH STATUS ASSESSMENT</p>	<ul style="list-style-type: none"> <input type="checkbox"/> ADMIT WEIGHT _____ kg <input type="checkbox"/> ADMIT HEIGHT _____ cm <input type="checkbox"/> BSA _____ m² <input type="checkbox"/> ADMIT PFT: (% Predicted) <li style="padding-left: 20px;">FVC _____ % FEV₁ _____ % <li style="padding-left: 20px;">FEF 25-75% _____ % <ul style="list-style-type: none"> ● OXIMETRY (Follow Oximetry Guidelines) ● ROUTINE RESPIRATORY ASSESSMENT (Cough, WOB, Sputum qty & color) 	<ul style="list-style-type: none"> <input type="checkbox"/> WEIGHT , biweekly : <li style="padding-left: 20px;">DATE: WEIGHT _____ <li style="padding-left: 40px;">_____ kg <li style="padding-left: 40px;">_____ kg <li style="padding-left: 40px;">_____ kg <ul style="list-style-type: none"> <input type="checkbox"/> PFT (% Predicted), biweekly: <table border="1" style="width: 100%; border-collapse: collapse; margin-left: 20px;"> <thead> <tr> <th style="width: 15%;">DATE</th> <th style="width: 15%;">%FVC</th> <th style="width: 15%;">%FEV₁</th> <th style="width: 15%;">%FEF 25-75%</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <ul style="list-style-type: none"> ● OXIMETRY (follow Guidelines) ● ROUTINE RESP ASSESSMENT 	DATE	%FVC	%FEV ₁	%FEF 25-75%													<ul style="list-style-type: none"> <input type="checkbox"/> WEIGHT _____ kg <input type="checkbox"/> PFT (% Predicted): <li style="padding-left: 20px;">FVC _____ % <li style="padding-left: 20px;">FEV₁ _____ % <li style="padding-left: 20px;">FEF 25-75% _____ % <ul style="list-style-type: none"> <input type="checkbox"/> SCHEDULE Annual Audiology Exam <li style="padding-left: 20px;">Date last done: _____
DATE	%FVC	%FEV ₁	%FEF 25-75%																



<p>PATIENT NAME: MR# BIRTH DATE:</p> <p style="text-align: center; margin-top: 20px;">(addressograph)</p>

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<p>LAB (See Standard CF Orders)</p>	<p><input type="checkbox"/> CHECK RESULTS of last Quant. Sputum Date Done: _____ If not done within last 30 days, send a QUANT SPUTUM to CF MicroLab</p> <p><input type="checkbox"/> VIT A&E,ALT,AST,CBC w Diff, PLT, U/A, GGT, Glucose (if >10 mo. since last) Date Last Done: _____</p> <p><input type="checkbox"/> TOBRAMYCIN LEVEL, with BUN/CR, with 3rd or 4th dose</p> <p>If NOT drawn correctly, results are INVALID</p> <p>▷ Levels MUST be drawn 30 minutes before & 30 minutes after the completion of the dose</p> <p>▷ Level CANNOT be drawn via central line</p> <p>TROUGH _____ mcg/mL (<2 mcg/mL) PEAK _____ mcg/mL (8-12 mcg/mL)</p> <p><input type="checkbox"/> OTHER KEY LAB FINDINGS (e.g. U/A, Glc)</p>	<p><input type="checkbox"/> TOBRAMYCIN LEVEL, with BUN/CR, q 7 days or post- dosage change</p> <p>If NOT drawn correctly, results are INVALID</p> <p>▷ Levels MUST be drawn 30 minutes before & 30 min after the completion of dose</p> <p>▷ Level CANNOT be drawn via central line</p> <p><input type="checkbox"/> Record Tobramycin DOSAGE CHANGES:</p> <p>NEW DOSE DATE</p> <p>_____mg IV _____</p> <p>_____mg IV _____</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 25%;">DATE</th> <th style="width: 25%;">TROUGH mcg/mL</th> <th style="width: 25%;">PEAK mcg/mL</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> <p><input type="checkbox"/> OTHER LABS / FINDINGS:</p>	DATE	TROUGH mcg/mL	PEAK mcg/mL										
DATE	TROUGH mcg/mL	PEAK mcg/mL													
<p>PULM FX (see Standard CF Orders)</p>	<p>✱ CPT tid to qid (circle method) Clapping Flutter Valve ThAirPy Vest</p> <p><input type="checkbox"/> OXYGEN to keep SaO2 ≥90%, or for patient comfort</p>	<p>✱ CPT tid to qid (circle method) Clapping Flutter Valve ThAirPy Vest</p> <p>✱ OXYGEN to keep SaO2 ≥90%, or for patient comfort</p>													
<p>NUTRITION MANAGEMENT (see Standard CF Orders)</p>	<p><input type="checkbox"/> CALORIE COUNT</p> <p><input type="checkbox"/> MEAL TICKETS</p> <p><input type="checkbox"/> SUPPLEMENT: <input type="checkbox"/> Enteral <input type="checkbox"/> PO _____</p> <p><input type="checkbox"/> G-Tube Type & Size: _____</p>	<p>✱ SUPPLEMENT</p>													
<p>MEDICATION (see Standard CF Orders)</p>	<p>SEE Medication Admin Record for complete list of medications</p> <p><input type="checkbox"/> Medication Plan includes : Y N</p> <p style="padding-left: 100px;">IV Abx <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 100px;">Steroids <input type="checkbox"/> <input type="checkbox"/></p>	<p>SEE Medication Admin Record for complete list of medications</p> <p><input type="checkbox"/> STEROID TAPER PLAN</p>													
<p>IV THERAPY</p>	<p><input type="checkbox"/> IV LINE: _____</p> <p><input type="checkbox"/> IV FLUID: _____ _____</p>	<p><input type="checkbox"/> IV LINE: _____</p> <p><input type="checkbox"/> IV FLUID: _____ _____</p>	<p><input type="checkbox"/> IV LINE DC'D</p>												

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CONSULTS	<p>Y N DATE DONE</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> _____ CF NUTRITIONIST</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> _____ CF SOCIAL WORK</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> _____ CF NURSE</p> <p><input type="checkbox"/> <input type="checkbox"/> _____ ENDOCRINE</p> <p><input type="checkbox"/> <input type="checkbox"/> _____ OTOLARYNGOLOGY</p> <p><input type="checkbox"/> <input type="checkbox"/> _____ PHYSICAL THERAPY</p> <p><input type="checkbox"/> _____</p>	<p>Y N DATE DONE</p> <p><input type="checkbox"/> <input type="checkbox"/> _____ SCHOOL/EDUCATION</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p>	<p><input type="checkbox"/> SCHEDULE Consult Service follow-up Appointment(s)</p>
EDUCATION & DISCHARGE PLANNING (see Discharge Teaching Tool)	<p><input type="checkbox"/> REINFORCE w pt/family the s/s of malabsorption</p> <p><input type="checkbox"/> REINFORCE w pt/family the s/s of respiratory distress & appropriate methods of respiratory treatment</p> <p><input type="checkbox"/> IDENTIFY additional Pt/Family need(s) for equipment, education & training for transition home & DOCUMENT on Discharge Teaching Tool</p> <p><input type="checkbox"/> REVIEW Transition Criteria (pg. 1) and identify barriers for transition to home</p> <p><input type="checkbox"/> IDENTIFY community resource needs and ARRANGE for provider referrals</p> <p><input type="checkbox"/> UPDATE community care providers with current plan of care</p> <p style="text-align: center;">IF PATIENT WILL BE DISCH HOME FOR PHASE TWO, TREATMENT:</p> <p><input type="checkbox"/> SCHEDULE Clinic Visit for Day 7-10 of therapy for clinical assessment, Tobramycin levels & PFT</p>	<p>IN-HOSPITAL PATIENT :</p> <p><input type="checkbox"/> Continue to ASSESS pt's Transition Criteria status (see Criteria, pg. 1)</p> <p><input type="checkbox"/> REVIEW Discharge Teaching Tool & IDENTIFY additional Pt/Family need(s) for equip., education & support for transition home/dc & ARRANGE for appropriate providers</p> <p><input type="checkbox"/> UPDATE community care providers with current plan of care</p> <p>HOME CARE PATIENT: (to be done by Home Health Provider)</p> <p><input type="checkbox"/> REVIEW Discharge Teaching Tool</p> <p><input type="checkbox"/> IDENTIFY additional ed, equip needs & PROVIDE or ARRANGE for services as indicated (& approved by MD, if necessary)</p> <p><input type="checkbox"/> UPDATE all providers with current plan of care</p>	<p><input type="checkbox"/> UPDATE all providers with status & plan for maintenance care</p> <p><input type="checkbox"/> REVIEW/UPDATE home/school maintenance medication plan</p> <p><input type="checkbox"/> SCHEDULE CF Clinic appt for 2 wks post-therapy</p>
PATIENT INFORMATION	<p>SECONDARY DIAGNOSES: _____</p> <p>ALLERGIES: _____</p> <p>RESEARCH PROTOCOL _____ CONTACT: _____</p> <p>HOME HEALTH AGENCY: _____ CONTACT: _____</p>		



PATIENT NAME: MR# BIRTH DATE: <p style="text-align: center;">(addressograph)</p>
