Diagnosis: _____ **BLOOMINGTON HOSPITAL CARDIOPULMONARY REHABILITATION** **Name:** _____

_____ **INDIVIDUALIZED PULMONARY TREATMENT PLAN** **DOB:** _____

_____

Physician: _____

Domain Goals (Required)	Initial/Date	Mid Program/Date	Exit/Date	Interventions: (initial/date)
Exercise Goal(s): (completion date: _____) 1) Patient will demonstrate improved exercise tolerance as measured by 6 minute walk test. 2) Patient will have improved tolerance of the following activity of daily living: _____ _____ (optimally: 30+ minutes of aerobic exercise most days of the week; resistance training 2-3x/week; maintenance of SaO2 ≥ 90%)	Evaluation: 6 min walk distance_____ Resting SpO2 _____ Exercise SpO2 _____ SOBQ Score _____ DI _____ **High Fall Risk :** Yes or No	Evaluation: **Home Exercise:** Mode: Duration: Frequency: RPE: DI: Home O2: Exercise Recommendations: _____ _____ **High Fall Risk :** Yes or No (Egress Test PRN) Evaluation: **Home Exercise:** Mode: Duration: Frequency: RPE: DI: Home O2: Exercise Recommendations: _____ _____ **High Fall Risk :** Yes or No (Egress Test PRN)	Evaluation: 6 min walk distance_____ Resting SpO2 _____ Exercise SpO2 _____ SOBQ Score _____ DI _____ **Home Exercise:** Mode: Duration: Frequency: RPE: DI: Exercise Plan/Recommendations (Discharge): _____ _____ **High Fall Risk :**Yes or No (Egress Test PRN)	Rehab sessions are provided 2-3 times per week for 12 to 36 sessions based on patient need and risk stratification. Each session lasts at least 1 hour and includes warm-up, 10 minutes of resistance training, 30 minutes of aerobic exercise, cool-down and stretches with continuous cardiac monitoring; progress as per policy. Refer to daily session reports. Adjust intensity of exercise to maintain RPE ≤_____, MET Level of _____ &/or DI ≤ _____. Titrate O2 to attempt to maintain SaO2 ≥ 90% per policy. Pt will be evaluated for safety prior to independent exercise or use of equipment as per policy. See daily session reports for actions taken to reduce risk of falls for those identified as high risk for falls. _____oriented to rehab gym/setting Pt. instructed on: _____DI, RPE, THR or MET level as guide for exercise. _____ signs/symptoms to report. _____ progression of exercise. _____ home exercise guidelines. _____ 6 min walk results. (see also patient education record for teaching

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				provided)

Domain Goals (Required)	Initial/Date	Mid Program/Date	Exit/Date	Interventions: (initial/date)

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Psychosocial Goal(s): (completion date: _____) 1) Improved QOL as measured by SF-12	Evaluation: BDI score:_____ Pre-SF12 completed: _____ Patient states adequate social/family support. Yes:_____ No:_____ Advance Directives: Yes:_____ No:_____	Evaluation: Patient states adequate social/family support. Yes:_____ No:_____	Evaluation: BDI score:_____ Post-SF12 completed: ___ Patient states adequate social/family support. Yes:_____ No:_____	_____physician notified for BDI score > 16 _____ vocational counseling as indicated _____ financial counseling as indicated _____ transportation arranged as indicated _____social services referral as indicated _____referral to pastoral care as indicated _____ pt. and family's individual needs/ preferences, cultural and spiritual beliefs addressed _____behavior health referral as indicated _____offered information on Advance Directives (See other interventions on treatment plan. See also patient education record for teaching provided.
Education Goal(s): (completion date: _____) 1) Patient will increase knowledge of their disease process and disease/risk factor management as evidenced by improved score on knowledge test.	Evaluation: Pulmonary Knowledge Test #Correct Pre-Program____	Evaluation:	Evaluation: Pulmonary Knowledge Test #Correct Post-program____	**pt. present for daily educational encounters in exercise sessions/see patient education record** _____reviewed infection control issues including hand hygiene and avoidance of exercise if ill. _____reviewed medications with patient _____denies questions re: medications _____education offered to meet specific patient needs or as requested. See education record . (See other interventions on treatment plan)

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Domain Goals (Required)	Initial/Date	Mid Program/Date	Exit/Date	Interventions: (initial/date)
Nutrition Goal(s): (completion date: _____)	Evaluation:	Evaluation:	Evaluation:	Nutrition workshop: _____ offered _____ declined _____attended _____ pt. received 1:1 nutritional evaluation/ education per dietician specific to his/ Her needs (see nutritional assessment) (See other interventions on treatment plan. See also patient education record for teaching provided)
Risk Factor Goals **Tobacco Goal(s):** (completion date: _____) (optimally: patient will refrain from all tobacco use)	Evaluation: Tobacco History: Type_____ How Long_____ How Much_____ Quit Date _____	Evaluation:	Evaluation:	_____ pt. provided tobacco cessation counseling **(required if uses tobacco)** _____ tobacco cessation packet given & explained to patient _____ pt. offered consultation with respiratory therapist _____ pt. offered tobacco cessation class _____ pt. attending/attended tobacco cessation class _____ pt. declines assistance with tobacco cessation (See other interventions on treatment plan. See also patient education record for teaching provided)

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Risk Factor Goals	Initial/Date	Mid Program/Date	Exit/Date	Interventions: (initial/date)
Hypertension Goal(s): (completion date: _____) (optimally < 120/80)	Evaluation: Resting B/P _____	Evaluation: Average rest B/P _____	Evaluation: Average rest B/P _____	B/P monitoring before & during exercise sessions; see daily session reports _____ physician notified of inadequate B/P control as indicated (See other interventions on treatmentt plan. See also patient education record/RD nutritional assessment for teaching provided)
Weight Management Goal(s) (completion date: _____) (optimally: BMI 18.5-24.9)	Evaluation: Height _____ Weight _____ BMI Score _____	Evaluation: Weight _____ Explanation For Lack of Weight Loss: _____Improved blood glucose control _____Maintaining recent weight loss _____Improved body composition _____Recent smoking cessation _____Fluid retention	Evaluation: Weight _____ BMI Score _____	_____ pt. has begun home exercise program _____pt has a plan for weight loss/gain (See other interventions on treatment plan. See also patient education record/RD nutritional assessment for teaching provided)

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Risk Factor Goals (cont.)	Initial/Date	Mid Program/Date	Exit/Date	Interventions: (initial/date)
Diabetes Goal(s): (completion date: _____) (optimally: Non-Diabetic: FBS<100 HgbA1c<5.7 Diabetic: FBS<120 HgbA1c 6.5-7)	Evaluation: Average FBS_____ HgbA1C _____	Evaluation: Average FBS _____ Average non-fasting blood glucose _____	Evaluation: Average FBS _____ Average non-fasting blood glucose _____	Blood glucose monitored before & after exercise per order/protocol (see daily session report for results-follow up as indicated). _____ pt. taught exercise precautions, effects of exercise on blood glucose, and signs and symptoms of hypoglycemia _____referral to Diabetes Center as indicated (See other interventions on treatment plan. See also patient education record/RD nutritional assessment for teaching provided)

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Additional Goal(s): (completion date: _____)	Evaluation:	Evaluation:	Evaluation:	

Initial Plan:

Patient Signature: _____ Date/Time: _____

Staff Signature: _____Initials: _____ Date/Time: _____

Physician Signature: _____ Date/Time: _____

Additional Staff Signatures/Initials:

Name: _____Initials: _____

Name: _____ Initials: _____

Name: _____ Initials: _____

Name: _____ Initials: _____

Physician Review:

I have reviewed treatment plan; continue with plan.

MD signature:_____Date/Time:_____

MD signature: _____Date/Time: _____

MD signature: _____Date/Time: _____

MD signature: _____Date/Time: _____

MD signature: _____Date/Time: _____

I *have reviewed progress and recommend the following changes in plan*:

_____

_____

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Physician: _____

Name: _____ Initials: _____ MD signature: _____Date/Time: _____

Name: _____ Initials: _____ _____

Name: _____ Initials: _____ _____

Name: _____ Initials: _____ MD signature: _____Date/Time: _____

Name: _____ Initials: _____ _____

Name: _____ Initials: _____ _____

Name: _____ Initials: _____ MD signature: _____Date/Time: _____