

NAME OF PATIENT	BIRTHDATE	DATE OF DIAGNOSIS
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SPIROMETRY

DATE	PATIENT'S FEV ₁ AS A PERCENT OF THEIR PREDICTED VALUE	FEV ₁ /FVC RATIO
<input type="checkbox"/> Confirmation of a post-bronchodilator FEV ₁ /FVC ratio of < 0.7 for a COPD diagnosis		

COPD CLASSIFICATION

By spirometry: Mild Moderate Severe Very severe

CARE OBJECTIVES

HEIGHT (in/cm)	WEIGHT (lbs/kg)	BMI	COMORBIDITIES <input type="checkbox"/> Cardiovascular disease <input type="checkbox"/> Musculoskeletal conditions <input type="checkbox"/> Metabolic syndrome <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Lung cancer <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Frailty <input type="checkbox"/> Other:
<input type="radio"/> Smoker <input type="radio"/> Never smoked <input type="radio"/> Ex-smoker - Quit date:			
VACCINATIONS	DATE(S) / INFORMATION		
<input type="checkbox"/> Annual Flu			
<input type="checkbox"/> Pneumococcal			
<input type="checkbox"/> Covid 19			
<input type="checkbox"/> Other			
PATIENT GOALS:			

PATIENT SELF MANAGEMENT

EDUCATION: <input type="checkbox"/> Discuss triggers and risk of exacerbations <input type="checkbox"/> Develop flare-up action plan <input type="checkbox"/> Refer to HLBC resource <input type="checkbox"/> Discuss advance care planning
SMOKING CESSATION: <input type="checkbox"/> Give Quit Now # 1 877 455-2233 <input type="checkbox"/> Refer to smoking cessation program
SET HEALTH BEHAVIOUR GOALS: <input type="checkbox"/> Encourage physical activity <input type="checkbox"/> Discuss meal planning and nutrition

ASSESSMENT

DATE (YYYY/MM/DD)									
REVIEW OF MEDICATIONS AND SIDE EFFECTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DISCUSS AND EVALUATE INHALER USE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STEP 1: SABA OR SAMA THERAPY (FOR SYMPTOM RELIEF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STEP 2: ADDITIONAL LAMA OR LABA THERAPY (FOR SYMPTOM RELIEF & PREVENT EXACERBATIONS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STEP 3: TRIPLE THERAPY (ADDITION OF ICS) (TO PREVENT EXACERBATIONS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEVERE COPD: SUPPLEMENTAL OXYGEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DATE OF LAST EXACERBATION (YYYY/MM/DD)									
REVIEW FLARE-UP ACTION PLAN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SHORT ACTING BRONCHODILATOR (FOR INITIAL TREATMENT OF ACUTE EXACERBATIONS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ORAL CORTICOSTEROIDS (E.G. PREDNISONE) (FOR MOST MODERATE TO SEVERE COPD PATIENTS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANTIBIOTIC TREATMENT (FOR PATIENTS PRESENTING WITH SYMPTOMS AND RISK FACTORS FOR BACTERIAL INFECTION)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REVIEW LIFESTYLE MANAGEMENT GOALS									
SMOKING CESSATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PRESCRIBE PHYSICAL ACTIVITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIETARY GUIDANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REFERRAL TO PULMONARY REHAB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REFERRAL TO SPECIALIST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>