

FRIENDSHIP VENTURES
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Session _____ Cabin _____

Cabin copy _____
Nurse copy _____

RESPIRATORY QUESTIONNAIRE

This form **MUST BE RECEIVED IN THE FRIENDSHIP VENTURES OFFICE 2 WEEKS PROR** to participation in any program.
Please plan to spend time with the nurse at check-in to review this form.

PARTICIPANT NAME: _____ DATES ATTENDING: _____

BE SURE TO **SEND ALL RESPIRATORY EQUIPMENT** and **EXTRA SUPPLIES**: masks, tubing, concentrator, adapters, filters, mouth pieces, portable oxygen tanks, nebulizers, inhalers, medications, and cleaning supplies, **TO CAMP**.

Is this participant bringing his/her own Personal Care Attendant? yes ___ no ___

Please state diagnosis or reason for participant having respiratory treatment/medication: _____

Date of this diagnosis: _____ Date of most recent medical event causing medical treatment: _____

Describe the applicants symptoms related to this diagnosis: _____

What causes this condition to worsen? _____

INHALERS/NEBULIZERS:

List medication(s) name, dose, frequency, and time:

Can the medications be *mixed* or must it be *given separately*? _____

Is there a waiting period between medications or treatments? (# of minutes between inhalers, between inhaler and neb. or is inhaler given *before* or *after* pummeling)? _____

If inhaler/medication is PRN (as needed) please state the criteria for use of each respiratory treatment/medication:

Equipment cleaning instructions: _____

BRONCHIAL DRAINAGE:

What pummeling equipment is used? manual ___ vest ___ tip board ___ other _____

How much time is spent on each lung base during pummeling? _____

Are lung sounds checked before or after pummeling? yes ___ no ___

If yes, please give detailed, step-by-step instructions of typical/atypical lung sounds and actions for staff to take:

OVER

CPAP / APNEA MONITOR

Please describe set up:

If alarm sounds, what action should staff take? _____

In the case of an electrical outage is this person dependent on equipment? yes ___ no ___

How long does back up battery last? _____

What is the emergency back up plan? _____

Equipment cleaning instructions: _____

OXYGEN ADMINISTRATION:

Does this person use oxygen? yes ___ no ___ If so, how much? _____ **Maximum** _____ **Minimum** _____

Please send portable back up tank(s).

If oxygen order is PRN (as needed), list criteria for administration: _____

In the case of an electrical outage is this person dependent on oxygen administration? yes ___ no ___

How long does back up battery last? _____

What is the emergency back up plan? _____

Equipment cleaning instructions: _____

ORAL SUCTIONING:

How often? _____ Sterile ___ Non-sterile ___

Please use the space below for any additional information you think we should know about this individual's suctioning concerns:

How long does back up battery last? _____

What is the emergency back up plan? _____

Equipment cleaning instructions: _____

Additional respiratory information that would be helpful in the care of this applicant:

_____	_____	_____	_____
NAME OF PERSON COMPLETING FORM	Relationship to applicant	PHONE	DATE

THANK YOU!