

SK CDM-QIP COPD Flow Sheet

Date Diagnosed with COPD: _____		Spirometry Confirmation of Diagnosis: Yes / No (post-bronchodilator FEV1/FVC <0.7)		Patient Name: _____	
Co-morbidities: <input type="checkbox"/> HF <input type="checkbox"/> Hypertension <input type="checkbox"/> Mental Health Condition <input type="checkbox"/> Asthma <input type="checkbox"/> CAD <input type="checkbox"/> OSA <input type="checkbox"/> CKD – stage ____ <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other _____		Date of Birth: _____		HSN: _____	
		Date:	Date:	Date:	
Severity of COPD	Most recent spirometry (FEV1 ___ % Predicted) (required for diagnosis; then q2-3 yrs as clinically indicated)	test date result	test date result	test date result	
	Severity of airflow limitation - based on post-bronchodilator FEV1	<input type="checkbox"/> mild – FEV1 ≥ 80% <input type="checkbox"/> moderate – FEV1 50-80% <input type="checkbox"/> severe – FEV1 30-50% <input type="checkbox"/> very severe – FEV1 <30%	<input type="checkbox"/> mild – FEV1 ≥ 80% <input type="checkbox"/> moderate – FEV1 50-80% <input type="checkbox"/> severe – FEV1 30-50% <input type="checkbox"/> very severe – FEV1 <30%	<input type="checkbox"/> mild – FEV1 ≥ 80% <input type="checkbox"/> moderate – FEV1 50-80% <input type="checkbox"/> severe – FEV1 30-50% <input type="checkbox"/> very severe – FEV1 <30%	
	Functional status - mMRC Dyspnea scale* <small>Grades: 0 – I only get breathless with strenuous exercise 1 – I get short of breath when hurrying on level ground or walking up a slight hill 2 – On level ground, I walk slower than people of the same age because of breathlessness, or I have to stop for breath when walking at my own pace on the level 3 – I stop for breath after walking about 100 yards or after a few minutes on level ground 4 – I am too breathless to leave the house or I am breathless when dressing</small>	Grade _____	Grade _____	Grade _____	
	*Non-COPD conditions may contribute to dyspnea				
Current COPD symptoms/activity	Cough / Wheeze	<input type="checkbox"/> none <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> more	<input type="checkbox"/> none <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> more	<input type="checkbox"/> none <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> more	
	Sputum (volume, colour)	<input type="checkbox"/> none <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> more	<input type="checkbox"/> none <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> more	<input type="checkbox"/> none <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> more	
	Fatigue	<input type="checkbox"/> none <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> more	<input type="checkbox"/> none <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> more	<input type="checkbox"/> none <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> more	
	Weight loss / gain	<input type="checkbox"/> No concerns <input type="checkbox"/> Yes:	<input type="checkbox"/> No concerns <input type="checkbox"/> Yes:	<input type="checkbox"/> No concerns <input type="checkbox"/> Yes:	
	Sleep disturbance	<input type="checkbox"/> No concerns <input type="checkbox"/> Yes:	<input type="checkbox"/> No concerns <input type="checkbox"/> Yes:	<input type="checkbox"/> No concerns <input type="checkbox"/> Yes:	
	Current physical activity / Change in exercise capacity				
	Physical activity advice & goals <small>(Physical activity recommended for all people with COPD)</small>				
Exacerbations	ER / Hospital since last visit <small>(why? / change in meds?)</small>				
	AECOPD since last visit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Patient has COPD action plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Implementation of Action Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Avg Number Exacerbations	<input type="checkbox"/> <1/yr <input type="checkbox"/> ≥ 1/yr	<input type="checkbox"/> <1/yr <input type="checkbox"/> ≥ 1/yr	<input type="checkbox"/> <1/yr <input type="checkbox"/> ≥ 1/yr	
Lifestyle	Smoking Status <small>(If Smoker, indicate actively quitting; contemplating quitting; no plan to quit; relapse)</small>	<input type="checkbox"/> Non-smoker <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Smoker _____	<input type="checkbox"/> Non-smoker <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Smoker _____	<input type="checkbox"/> Non-smoker <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Smoker _____	
	Ex-smoker quit date				
	Smoking Cessation Advice (if required)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Examination	Weight (kg)				
	Pulse				
	BP				
	Oxygen Sat (%) <small>Specify if room air or with supplemental O2</small>				
	Respiratory exam				

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	Date:	Date:	Date:	
Medications	SABD <i>(indicated for prn use in mild COPD without or with LABA or LAAC)</i> Drug name/Dose:	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford
	LAAC/LAMA (Anticholinergic) <i>(indicated for: mild COPD LAAC + SABD prn; moderate COPD LAAC + LABA + SABD prn; COPD with frequent AECOPD LAAC + ICS/LABA)</i> Drug name/Dose:	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford
	LABA <i>(indicated for: mild COPD LABA + SABD prn; moderate COPD LABA + LAAC + SABD prn)</i> Drug name/Dose:	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford
	ICS in combination with LABA <i>(indicated for moderate - severe COPD with frequent AECOPD ≥ 1/year in combination with LAAC)</i> Drug name/Dose:	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> continue <input type="checkbox"/> start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - Pt. refused <input type="checkbox"/> No - unable to afford
	Other COPD medications			
	Medication Adherence/Comments			
	Ensure correct inhaler technique: consider spacer and/or formal education <i>(SK Lung Association, Pharmacist, Nurse educator)</i>	<input type="checkbox"/> Reviewed <input type="checkbox"/> Education recommended	<input type="checkbox"/> Reviewed <input type="checkbox"/> Education recommended	<input type="checkbox"/> Reviewed <input type="checkbox"/> Education recommended
	Supplemental Oxygen need reviewed <i>(assess if: O₂ sat ≤ 92% breathing room air; FEV₁ <50% predicted; evidence of pulm hypertension, HF, polycythemia)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
OSA screen	Screen for Obstructive Sleep Apnea <i>(do annually; use Berlin or STOP BANG questionnaires and sleep study if needed)</i>	<input type="checkbox"/> Screened today <input type="checkbox"/> Referred for sleep study <input type="checkbox"/> Known OSA diagnosis	<input type="checkbox"/> Screened today <input type="checkbox"/> Referred for sleep study <input type="checkbox"/> Known OSA diagnosis	<input type="checkbox"/> Screened today <input type="checkbox"/> Referred for sleep study <input type="checkbox"/> Known OSA diagnosis
	Influenza <i>(annual)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes Reason:	<input type="checkbox"/> No <input type="checkbox"/> Yes Reason:	<input type="checkbox"/> No <input type="checkbox"/> Yes Reason:
Vaccines	Pneumococcus <i>(once; repeat if >65yr & very high risk for this infection)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No – Reason:		
	Screened for Depression, Anxiety, other Stressors <i>(consider use of PHQ-9, GAD-7)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No Concerns:	<input type="checkbox"/> Yes <input type="checkbox"/> No Concerns:	<input type="checkbox"/> Yes <input type="checkbox"/> No Concerns:
Management Plans	Referral to Pulmonary Rehab Program	<input type="checkbox"/> Attending currently <input type="checkbox"/> Interested, will refer <input type="checkbox"/> Not indicated – medical reason <input type="checkbox"/> Patient declined <input type="checkbox"/> Barrier (financial/access) <input type="checkbox"/> Resource not available	<input type="checkbox"/> Attending currently <input type="checkbox"/> Interested, will refer <input type="checkbox"/> Not indicated – medical reason <input type="checkbox"/> Patient declined <input type="checkbox"/> Barrier (financial/access) <input type="checkbox"/> Resource not available	<input type="checkbox"/> Attending currently <input type="checkbox"/> Interested, will refer <input type="checkbox"/> Not indicated – medical reason <input type="checkbox"/> Patient declined <input type="checkbox"/> Barrier (financial/access) <input type="checkbox"/> Resource not available
	Patient goals / self-management			
	End of life / Advanced care directive discussion			
	Referrals made <i>(refer to specialist if: frequent AECOPD; failure to achieve expected response to therapy; multiple comorbidities; rapid clinical deterioration)</i>	<input type="checkbox"/> Certified Resp. Educator <input type="checkbox"/> Respiriologist <input type="checkbox"/> Other	<input type="checkbox"/> Certified Resp. Educator <input type="checkbox"/> Respiriologist <input type="checkbox"/> Other	<input type="checkbox"/> Certified Resp. Educator <input type="checkbox"/> Respiriologist <input type="checkbox"/> Other
	Resources given to patient <i>COPD action plan, Advanced health care directive, educational materials</i>			

For additional CDM-QIP resources, please visit www.sma.sk.ca/cdm