The Royal Children's Hospital Melbourne

UR NUMBER
SURNAME
GIVEN NAME(S)
DATE OF BIRTH
AFFIX PATIENT LABEL HERE ↑

Cystic Fibrosis annual review

Annual review appointment date: Age:
Address:
CF physician:
GP: Paediatrician:

Background history:

Cystic fibrosis diagnosis:

Genotype: Class:
Sweat chloride: Age at diagnosis:
Mode of presentation:

Problem list:

Active:

1. 5.
2. 6.
3. 7.
4. 8.

Inactive:

Medical history (non-CF):

1. 3.
2. 4.

Current medications:

1. 8.
2. 9.
3. 10.
4. 11.
5. 12.
6. 13.
7. 14.

Allergies:

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RESPIRATORY

At baseline:

Cough:	☐ None	☐ Dry	☐ Moist	
If moist:	☐ With physio	☐ With exercise	☐ At other times	
Sputum consistency:	☐ Thick	☐ Thin	☐ Sticky	☐ Hard to cough up
Sputum amount:	☐ None	☐ Teaspoon	☐ Tablespoon	☐ Bottom of cup
	☐ ¼ cup	☐ >¼ cup		
Shortness of breath:	☐ Yes	☐ No		

Comments:

Lung function:

Investigations:

CT Chest:

CXR:

ABPA: ☐ Yes ☐ No

Screen:

Admissions in past 12 months:

Date	Duration	Reason	Management	HITH

Comments:

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Physiotherapy review:

Based on: ☐ A/R appointment ☐ Outpatient notes ☐ Inpatient assessment

Airway clearance:

Regular routine:

Routine with exacerbation:

Technique reviewed: ☐ Yes ☐ No

Suggested changes:

Airway clearance and inhalation therapy timeline:

Morning	Afternoon	Evening
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

Suggested changes:

Home nebuliser type:

Activity and Exercise:

Exercise test: Type:

This year – Date:

Level achieved	SpO_2	HR	Breathlessness	Leg fatigue
	Pre: Post:	Pre: Post:	Pre: Post:	Pre: Post

Last year – Date:

Level achieved	SpO_2	HR	Breathlessness	Leg fatigue
	Pre: Post:	Pre: Post:	Pre: Post:	Pre: Post:

Infection:

Number of specimens collected in past 12 months: gjksjkg

Respiratory pathogens in past 12 months:

☐ *S. Aureus* ☐ *S. maltophilia* ☐ *Aspergillus*

☐ *H.influenzae/H. parainfluenzae* ☐ *Achromobacter*

☐ *P. aeruginosa* Eradication past 12 months: ☐ Inpatient ☐ Outpatient

☐ NTM ☐ Negative ☐ Not done Species:

☐ Other

Ever infected with *Pseudomonas*: ○ Yes ○ No Dates (years):

Chronically infected with:

Cohort:

Maintenance antibiotic regimen:

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GASTROINTESTINAL

DIOS (past 12 months): ◯ Yes ◯ No

Management:

CF-related liver disease: ◯ Yes ◯ No

Abdominal ultrasound:

LFTs:

If CF-related liver disease:

Gastro-CF clinic: ◯ Yes ◯ No

Portal Hypertension: ◯ Yes ◯ No

Platelets: INR: Albumin:

NUTRITION

Enzymes:

Salt supplements :

Vitamin supplements:

Nutritional supplements: ◯ Yes ◯ No

Enteral feeds: ◯ Yes ◯ No

Date gastrostomy inserted:

Nutritional parameters:

Fat-soluble vitamin status:

Iron status:

Zinc status:

Nutritional support and food diary:

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Growth:

ENDOCRINE

CF-related diabetes: ○ Yes ○ No

OGTT:

If CF-related diabetes:

HbA1c:

Insulin:	○ Yes	○ No	Doses:
Endocrinology clinic:	○ Yes	○ No	Other comments:

Vitamin D:

Deficiency:	○ Yes	○ No	Level:	Date:
Stoss dose:	○ Yes	○ No	Date:	
Maintenance:	○ Yes	○ No		

Bone density:

DEXA scan:

MUSCULOSKELETAL CONCERNS

CONTINENCE

OTHER MEDICAL CONCERNS

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PSYCHOSOCIAL

Family information:

Education and extracurricular activities:

Days of school missed in past year:

Social and community supports:

Other RCH supports:

Benefits:

- ☐ Carer allowance with health care card
- ☐ Disability support pension
- ☐ Ex-carer allowance
- ☐ Medical equipment payment
- ☐ Victorian carer card
- ☐ Others:

CF knowledge, adherence and impact of illness:

Screening assessments:

Transition:

Transition checklist: ☐ 10-13 yrs ☐ 14-16 yrs ☐ 16-18 yrs ☐ N/A
Comments:

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ADDITIONAL INFORMATION

Outpatient appointments:

Clinic	Scheduled	Attended
CF clinic		
Resp Med (inc A/R)		
Drop in (resp)		
Gastroenterology		
Endocrinology		
Psychology		
Other		

IV Access during admission:

☐ PORT-A-CATH ☐ Midline ☐ PICC ☐ CVC

Sedation requirement:

☐ GA ☐ Midazolam ☐ Nitrous Oxide ☐ Awake ☐ N/A

Comments:

Research studies: ☐ AREST ☐ COMBAT ☐ Other (please list)

Preventative health:

Routine immunisations**:** ○ Up to date ○ No

Influenza vaccine**:** ○ Yes ○ No

Household smoke exposure**:** ○ Yes ○ No Comments:

Additional comments:

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SUMMARY

Medical summary: Compiled by: Date:

Physiotherapy summary: Compiled by: Date:

Nutrition summary: Compiled by: Date:

Psychosocial summary: Compiled by: Date:

Follow up of previous annual review recommendations:

Recommendations for this year:

Consultant: Signature: Date: