PEP Device Therapy Adherence Assessment Follow-Up Form

Date of Assessment: ________ 7 Days ____ 30 Days ____ 60 Days ____ 180 Days____

Patient Name: ___________________________________ Date Patient Received PEP Device: ___________

Please answer the following questions based on your experience with the PEP Device:

Are you still using the PEP Device according to your Doctor's prescription? If no, when did you stop using it?
____

How many breaths and treatments per day are you using the PEP Device?

Breaths______ Treatments Per Day________

Please rate your response to the following questions since beginning your treatments with the PEP Device.

Please check the appropriate response: (1 = Strongly disagree 2 = disagree 3 = same 4 = agree 5 = strongly agree)

My breathing has improved	1___ 2___ 3___ 4___ 5___
My secretions have improved	1___ 2___ 3___ 4___ 5___
My sleep has improved	1___ 2___ 3___ 4___ 5___
My treatment regimen has improved	1___ 2___ 3___ 4___ 5___
My activity/energy level has improved	1___ 2___ 3___ 4___ 5___
My quality of life has improved	1___ 2___ 3___ 4___ 5___
I received proper training	1___ 2___ 3___ 4___ 5___

Do you understand the benefits of daily use of your PEP Device? Yes No

Since you began using the PEP Device, have you required treatment with antibiotics or any other medications to treat a respiratory/lung infection? If yes, how many times has this occurred?
____

Since you began using the PEP Device, have you required hospitalization related to your respiratory condition? If yes, when and where?
____

Since you began using the PEP Device, have you required a visit to the emergency room or urgent care related to your respiratory condition? If yes, when and where?
____

Who is your current physician you are seeing for your Respiratory issues? _______________________

Do you feel you need any additional instruction? Yes No

Additional Comments:

____
____
____
____

Name of person completing survey: ____

Relationship to person: ____

Date form completed: ____

Respiratory Therapist who completed phone assessment: _________________________

Respiratory Therapist Notes:

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Further Recommendations:

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