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| **DETAILS** | Office 4—Wester Meathie, |
|  | **PLEASE MAKE A COPY OF THIS DOCUMENT FOR** |
|  | **YOUR RECORDS, AND EITHER EMAIL IT TO :** |
|  | **casestudies@wrightfoundation.com** |
|  | **OR POST THE ORIGINAL TO :** |
| **RETURN** | Inverarity |
| By Forfar, |
|  |

Angus, DD8 1XJ.

8



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| **HOSPITAL ATTENDANCE RECORD** |

**Leading by Achievement & Example**

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**PULMONARY**

**REHABILITATION**

**“in the community”**

NAME

COURSE ATTENDED

DATE

**Pulmonary Rehabilitation Sessions**

**hospital attendance record**

a. Office 4—Wester Meathie, Inverarity, By Forfar, Angus, DD8 1XJ. t. 01307 469055

1. info@wrightfoundation.com w. www.wrightfoundation.com

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| **VISIT REQUIREMENTS** |

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**Viewing of Pulmonary Rehabilitation**

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You are required to attend at least four sessions (totalling at least eight hours) viewing Pulmonary Rehabilitation over a maximum of five weeks with-in a local hospital.

You will view patients on their initial visit to the Pulmonary Rehabilitation programme to under-stand the physical condition and their ability to undertake an activity schedule. It is important that you understand the considerations as the patient progresses through the full pulmonary pro-gramme, in particular, how their condition is assessed.

During these stages of progression, you must view and understand the changes to the patient/client’s condition and attitude to exercise/activity. This is particularly important as the patient completes their Pulmonary Rehabilitation hospital pro-gramme.

2



Please outline your general impressions of the Pulmonary Rehabilitation sessions you have observed. **Minimum 100 words.**

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NAME OF HOSPITAL



DATE OF SESSION

TIME OF SESSION

FROM: TO:

To:

From: 

BRIEF OUTLINE OF SESSION **(50 words minimum)**

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| **SESSION 4** |

HOSPITAL REPRESENTATIVE NAME (BLOCK CAPITALS)

HOSPITAL REPRESENTATIVE POSITION

HOSPITAL REPRESENTATIVE SIGNATURE



6



NAME OF HOSPITAL



DATE OF SESSION



TIME OF SESSION



To:

From: 

FROM: TO:

BRIEF OUTLINE OF SESSION **(50 words minimum)**

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|  |
| --- |
| **SESSION 1** |

HOSPITAL REPRESENTATIVE NAME (BLOCK CAPITALS)



HOSPITAL REPRESENTATIVE POSITION



HOSPITAL REPRESENTATIVE SIGNATURE



3



NAME OF HOSPITAL



DATE OF SESSION



TIME OF SESSION



To:

To:

From: 

FROM: TO:

BRIEF OUTLINE OF SESSION **(50 words minimum)**

****

|  |
| --- |
| **SESSION 2** |

HOSPITAL REPRESENTATIVE NAME (BLOCK CAPITALS)



HOSPITAL REPRESENTATIVE POSITION



HOSPITAL REPRESENTATIVE SIGNATURE



4



NAME OF HOSPITAL



DATE OF SESSION



TIME OF SESSION



To:

From:

FROM: TO:

BRIEF OUTLINE OF SESSION **(50 words minimum)**

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|  |
| --- |
| **SESSION 3** |

HOSPITAL REPRESENTATIVE NAME (BLOCK CAPITALS)



HOSPITAL REPRESENTATIVE POSITION



HOSPITAL REPRESENTATIVE SIGNATURE



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