LCHC Leadership Council for Healthy Communities

Respiratory Wellness Monthly Report

Name of Site _____

Month _____ **Year** _____ **Ward** _____

Date of Activity _____ **No. of Hours** _____ **No. of Attendees** _____

A. Health Topic/Information Disseminated:

COPD _____ **How Many** _____

Asthma _____ **How Many** _____

B. No. of Pre and Post Test Administered _____

C. Referral(s)

Referrals Made	Organization Referred to	Reason for Referral	Status of Referral

Please indicate any technical assistance needs: _____

Next activity planned: _____ **Date:**

_____ _____

Signature of Authorized Representative **Date**

Contact Number:

Note: Reports are due by the 7th business day of the month for the prior month.