

ASTHMA EDUCATION INVENTORY

Patient Number : _____ Date: ___/___/___ Name: _____
 Patient's Age: _____ DOB: ___/___/___ Male Female Caregiver's Name: _____
 Language Preference: English Spanish Other _____
 Attending Physician: _____ Last Physician Visit at Clinic: ___/___/___
 Session Conducted by: Asthma Educator 1 Asthma Educator 2
 Where session occurred: Clinic Telephone Home Visit Type of session: Initial Follow up # _____
 Session Start Time: _____ Session End Time: _____ Session Length: _____ minutes

CONTROL		Age 0-4		
*Impairment	Symptoms	≤ 2 days/week but not more than once on each day ___	>2days week, or multiple times on ≤ 2 days/ week ___	Throughout the day ___
	Nighttime awakenings	≤ 1x/month ___	>1x /month ___	>1x/week ___
	Interference with normal activity	None ___	Some limitation ___	Extremely limited ___
	SABA	≤ 2 days/week ___	>2 days/week ___	Several times per day ___
RISK	Exac. Oral Sys. Corticosteroids	0-1x/year ___	2-3x/year ___	>3x/year ___
	Level of Control	Well Controlled ___	Not Well Controlled ___	Very Poorly Controlled ___

CONTROL		Age 5-11		
*Impairment	Symptoms	≤ 2 days/week but not more than once on each day ___	> 2days week, or multiple times on ≤ 2 days/ week ___	Throughout the day ___
	Nighttime awakenings	≤ 1x/month ___	≥ 2x/month ___	≥ 2x/week
	Interference with normal activity	None ___	Some limitation ___	Extremely limited ___
	SABA	≤ 2 days/week ___	>2days week ___	Several times per day ___
	Lung function			
	FEV ₁ or peak flow	>80% predicted/pbest ___	60-80% predicted/pbest ___	<60% predicted/pbest ___
	FEV ₁ /FVC	>80% ___	75-80% ___	<75% ___
RISK	Exac. Oral Steroids	0-1x/year ___	≥2x/year ___	≥2x/year ___
	Level of Control	Well Controlled --- ___	Not Well Controlled --- ___	Very Poorly Controlled --- ___

CONTROL		Age 12-Adult		
*Impairment	Symptoms	≤ 2 days/week ___	>2days week ___	Throughout the day ___
	Nighttime awakenings	≤ 2x/month ___	1-3 x/week ___	≥4x/week ___
	Interference with normal activity	None ___	Some limitation ___	Extremely limited ___
	SABA	≤2 days/week ___	>2 days/week ___	Several times per day ___
	FEV ₁ or peak flow	>80% predicted/pbest ___	60-80% predicted/pbest ___	<60% predicted/pbest ___
	ACT score	≥ 20 ___	16 -19 ___	≤ 15 ___
RISK	Exac. Oral Systemic Corticosteroids	0-1 year ___	≥ 2 year ___	≥ 2 year ___
	Reduction in Lung Growth	Requires long-term follow up	Requires long-term follow up	Requires long-term follow up
	Level of Control	Well Controlled ___	Not Well Controlled ___	Very Poorly Controlled ___

Asthma Control Level Assessed by: MD Asthma Educator *Assess Impairment Domain by recall of previous 2-4 weeks.

Impairment and Risk Factors

Physician Assessment of Asthma Severity Level

Intermittent

Mild Persistent

Moderate Persistent

Severe Persistent

Symptoms in past 4 weeks: Coughing Wheezing Chest Tightness Difficulty Breathing Feeling Out Of Breath

***How many symptom days in past 4 weeks?** _____

***How many school days missed since last visit/last 3 months if initial visit?** _____

Have you had any asthma attacks since your last visit/ last 3 months if initial visit? No Yes When _____

FEV₁ Score _____ Peak Flow Rating _____ Peak Flow Predicted _____ FEV₁/FVC _____

Was spirometry performed in the last year? Yes No Date of last spirometry _____

Asthma Control Test Score: _____ Childhood Asthma Control Test Score: _____

Healthcare Utilization

***Has child been in Emergency Room since last visit/last year if initial visit?** No Yes , when _____

***Has child been hospitalized since last visit/last year if initial visit?** No Yes , when _____

How many oral corticosteroid bursts since last visit/last year if initial visit? None 1 2 3 Other specify how many

Allergy testing ordered by DCSNO Yes No

Allergy testing results: negative dust mites dog cat cockroach mold(s) rodents grass tree pollen weed pollen
other _____

Date of testing: _____

Results pending **Testing not performed** **Why not:** _____

Known Triggers: _____

Child Exposed to Tobacco Smoke: Yes No **Child Smokes:** Yes No

Current Medications

Name _____ Dose _____ How Often _____ How often taken in last 2 weeks _____ Med prescribed by _____

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Name _____ Dose _____ How Often _____ How often taken in last 2 weeks _____ Med prescribed by _____

*How many days have you missed your ICS in last 2 weeks? _____ Not applicable

SABA use in last 2 weeks _____

*Asthma Action Plan Completed: Yes No

Inhaler Technique Checklist (check steps that need improvement)

Metered Dose Inhaler

1. Shake the inhaler and remove the protective cap
2. Hold inhaler upright
3. Exhale to residual volume
4. Place mouthpiece between lips and teeth
5. Inhale slowly and simultaneously activate the canister
6. Continue slow and deep inhalation
7. Hold breath for 5-10 seconds
8. Take inhaler out of mouth and hold breath for 5-10 seconds

Dry Powder Inhaler

1. Prepare the inhaler before usage
2. Keep inhaler horizontal
3. Exhale to residual volume
4. Place mouthpiece between lips and teeth
5. Inhale forcefully and deeply
6. Take the inhaler out of the mouth
7. Hold breath for 5 seconds

Device Technique:

Nebulizer MDI MDI with Spacer DPI Diskus Peak Flow Meter
 Independent use: Minimum coaching: Moderate coaching: Maximum coaching:

Additional Device Technique:

Nebulizer MDI MDI with Spacer DPI Diskus Peak Flow Meter
 Independent use: Minimum coaching: Moderate coaching: Maximum coaching:

Additional Device Technique:

Nebulizer MDI MDI with Spacer DPI DPI Diskus Peak Flow Meter
 Independent use: Minimum coaching: Moderate coaching: Maximum coaching:

Notes: _____

In-Check Dial Rating for Quick Relief _____	Optimum Inspiratory Flow _____
In-Check Dial Rating for Controller _____	Optimum Inspiratory Flow _____
Rating for Additional Medication _____	Optimum Inspiratory Flow _____
MDI 25 to 60 L/min	Flexhaler 60 to 90 L/min
Twisthaler/Autohaler 30 to 60 L/min	Aerolizer 25 to 90 L/min
	Diskus 30 to 90 L/min
	Handihaler 20 to 90 L/min

Child Asthma Risk Assessment Tool (CARAT) Scores

Low risk factors 1-3, moderate risk factors 4-6, high risk factors 7-10.

Medical Care <input type="checkbox"/>	Environmental <input type="checkbox"/>	Smoking <input type="checkbox"/>
Responsibility <input type="checkbox"/>	Adherence <input type="checkbox"/>	Adult Well-Being <input type="checkbox"/>
Child Well-Being <input type="checkbox"/>	Asthma Attitudes <input type="checkbox"/>	Allergies <input type="checkbox"/>

Problems Taking Medications:

Concern about medication side effects <input type="checkbox"/>	Caregiver fears child will become addicted to medication <input type="checkbox"/>
Mechanical problems using delivery device <input type="checkbox"/>	Obtaining medications <input type="checkbox"/>
Participant questions need for medication because feels well <input type="checkbox"/>	Affording medications <input type="checkbox"/>
Caretaker questions need for medication because child appears well to them <input type="checkbox"/>	Complicated family lifestyle <input type="checkbox"/>
Remembering to take medications <input type="checkbox"/>	Use of folk remedies <input type="checkbox"/>
Medication is not working <input type="checkbox"/>	Resistant to taking medication due to peer pressure <input type="checkbox"/>
Child refuses to take medication <input type="checkbox"/>	Lack of adult supervision <input type="checkbox"/>
Difficulty persuading child to take medication <input type="checkbox"/>	No spacer <input type="checkbox"/> Spacer given <input type="checkbox"/>
Caregiver/child does not understand importance <input type="checkbox"/>	No peak flow meter <input type="checkbox"/> Peak flow meter given <input type="checkbox"/>

Other _____

Asthma Education Completed

- Review of symptoms
- Types of asthma medications
- Adherence
- Device technique
- Nebulizer use
- Review of Asthma Action Plan
- Self management practices
- Asthma triggers/ avoiding triggers
- Exercise induced asthma
- ACT 145

- What is asthma?
- How to handle an asthma attack
- Safety of medications
- Spacer
- Peak Flow Meter
- Goals of therapy/ criteria of successful treatment
- Early warning signs
- Smoking cessation
- Managing asthma at school
- Review of goals

Other _____

Handouts Given: _____

Self Management Goals Established Yes No

- | | | | |
|----------------------|---|--|--|
| Environmental: | smoking cessation <input type="checkbox"/> | environmental remediation <input type="checkbox"/> | avoidance of triggers <input type="checkbox"/> |
| Medication: | adherence <input type="checkbox"/> | device <input type="checkbox"/> | timely filling of RXs <input type="checkbox"/> |
| Symptom Recognition: | peak flow monitoring <input type="checkbox"/> | recognizing early warning signs <input type="checkbox"/> | following AAP <input type="checkbox"/> |

Follow up with physician

Current AAP at school/ACT 145

Other _____

Notes: _____

