Referral Form

Program ID _____

REFERRAL FORM

1. Date of Referral: _____

1a. Is this a re-enrollment?
- ☐ Yes
- ☐ No (new client)

1b. What is the client's previous case #? _____

2. Referrer site:
- ☐ Asthma/Allergy Specialist
- ☐ CHC
- ☐ ED
- ☐ Inpatient
- ☐ Nurse
- ☐ PCP
- ☐ School
- ☐ Other

2a. If other, please specify: _____

3. Referrer name: _____

4. Hospital/Health Center? (Referral Site)

- ☐ Atrius Health
- ☐ Beth Israel Deaconess Medical Center
- ☐ Boston Children's Hospital
- ☐ Boston Medical Center
- ☐ Bowdoin Street Health Center
- ☐ Brigham And Women's Hospital
- ☐ Brookside Community Health Center
- ☐ Caritas Carney Hospital
- ☐ Caritas Saint Elizabeth's Medical Center
- ☐ Codman Square Health Center
- ☐ Dimock Community Health Center
- ☐ Dot House
- ☐ East Boston Neighborhood Health Center
- ☐ Faulkner Hospital
- ☐ Fenway Community Health Center
- ☐ Geiger-Gibson Community Health Center
- ☐ Greater Roslindale Medical And Dental Center
- ☐ Harvard Street Neighborhood Health
- ☐ Harvard Medical Associates (Copley, Kenmore, West Roxbury)
- ☐ Harvard Vanguard
- ☐ Martha Eliot Health Center
- ☐ Massachusetts General Hospital
- ☐ Mgh/Back Bay Health Care Center
- ☐ Mgh/Charlestown Health Care Center
- ☐ Neponset Health Center
- ☐ North End Community Health Center
- ☐ South Boston Community Health Center
- ☐ South Cove Community Health Center
- ☐ South End Community Health Center
- ☐ Southern Jamaica Plain Health Center
- ☐ St. Elizabeth's Health Care @Brighton Marine
- ☐ Tufts Medical Center
- ☐ Uphams Corner Health Center
- ☐ Whittier Street Health Center
- ☐ Other

4a. If other Referral site, please list: _____

5. Insurance:

- ☐ Free Care
- ☐ MassHealth
- ☐ None
- ☐ Private
- ☐ Other (SCHIP)
- ☐ Missing

5a1. If other, please specify: _____

5a2. If MassHealth, MassHealth Insurance Type:

- ☐ BMC Healthnet
- ☐ MassHealth
- ☐ Network Health
- ☐ NHP
- ☐ Non-PCC
- ☐ PCC
- ☐ N/A
- ☐ Other

5a3. If other, please specify: _____

5b. If Private Insurance, Private Insurance Type:

- ☐ BCBS
- ☐ BMC HealthNet
- ☐ CelticCare
- ☐ COMMONWEALTH CARE
- ☐ Connecticare
- ☐ Fallon Community Health Plan
- ☐ Harvard Pilgrim
- ☐ Medicare
- ☐ Network Health
- ☐ Tufts Health Plan
- ☐ United Health Care
- ☐ Other
- ☐ Unknown

5c. If other private insurance, please list: _____

Client Information

6. Language

- ☐ Cantonese
- ☐ English
- ☐ Haitian-Creole,
- ☐ Mandarin
- ☐ Spanish
- ☐ Other

6a. If other, please specify: _____

7. DOB (Y-M-D) _____

8. Age _____

9. Criteria for Referral (Check all that apply)

- ☐ Animal Dander
- ☐ Chemicals (cleaning chemicals, pesticides)
- ☐ Concerns about home environmental triggers
- ☐ Concerns about Medication Adherence
- ☐ Dust mites
- ☐ Environmental Tobacco Exposure
- ☐ Hospital Admission Asthma Exacerbation (12 mo)
- ☐ Mice
- ☐ Mold
- ☐ More than one course of oral steroids (last 12 mo)
- ☐ Needs help with med administration
- ☐ Overuse of rescue medications (past 6 mo)
- ☐ Patient Smokes
- ☐ Pollen
- ☐ Poorly Controlled Persistent Asthma
- ☐ Repeated ER or Urgent Care visits (past 12 mo)
- ☐ Roaches
- ☐ Other

9a. If other list here: _____

Other Pertinent Information

10. Allergy Testing Conducted

- ☐ Yes
- ☐ No
- ☐ Do not know

10a. What kind of allergy test was conducted?

- ☐ RAST
- ☐ Skin Test
- ☐ I don't know

10b. Positive Allergy Testing Results:

- ☐ Animal Dander
- ☐ Cat
- ☐ Dog
- ☐ Dust-mites
- ☐ Feathers
- ☐ Grass
- ☐ Horse
- ☐ Housedust
- ☐ Mice
- ☐ Molds
- ☐ Pollen
- ☐ Roaches
- ☐ Trees
- ☐ Weeds
- ☐ Other

10b1. If other positive allergy list here: _____

11. Asthma Action Plan Attached?

- ☐ Yes
- ☐ No

12. Controller Medication Prescribed (name and dosage)

- ☐ Advair discus 100/50
- ☐ Advair discus 250/50
- ☐ Advair discus 500/50
- ☐ Advair MDI inhaler 45/21
- ☐ Advair MDI inhaler 115/21
- ☐ Advair MDI inhaler 230/21
- ☐ Alvesco 80mcg
- ☐ Alvesco 160mcg
- ☐ Asmanex 110 mcg
- ☐ Asmanex 220 mcg
- ☐ Dulera 100mcg/5mcg
- ☐ Dulera 200mcg/5mcg
- ☐ Flovent 44mcg
- ☐ Flovent 110mcg
- ☐ Flovent 220mcg
- ☐ Pulimicort flexhaler 90mcg
- ☐ Pulmicort flexhaler 180mcg
- ☐ Pulmicort respules 0.25mg
- ☐ Pulimicort respules 0.50mg
- ☐ QVAR 40mcg
- ☐ QVAR 80mcg
- ☐ Singulair 4mg
- ☐ Singulair 5mg
- ☐ Singular 10mg
- ☐ Symbicort 160/2.5
- ☐ Symbicort 80/4.5
- ☐ Other

(Please decide if easier to just type in text box above or if this is better with drop down.)

12a. If other, please specify _____

12b. How many puffs?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ Other

12b1. If other, then how many puffs? _____

12c. How many times daily?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ Other

12c1. If other, how many times daily? _____

13. Equipment Prescribed (Check all that apply)

- ☐ Nebulizer
- ☐ Spacer
- ☐ Spacer with Mask
- ☐ Other

13a. If other, please specify _____

14. Referral Form Comments _____

Data Collection

DATA COLLECTION

BPHC Data Collection Tool Kit Remember- this form only needs to be filled out on the First VISIT ONLY

CHW MUST READ OUT LOUD TO CLIENT.
Why we collect this information: My organization is in partnership with the City's Health Department and is interested in learning more about inequalities in health. We want to make sure that all our patients get the best possible care, regardless of their race or ethnic background. We would like you to tell us your race or ethnicity so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. The collection of this information is confidential and voluntary. It will not affect the delivery of services nor ever be used to discriminate in the provision of services.

1. How would you describe your ethnicity? You can choose more than one. (Only if the respondent indicates s/he does not understand what is meant by ethnicity, you may add "Where were you or your parent/grandparents born?")

- ☐ Afghanistani
- ☐ African
- ☐ African American
- ☐ Albanian
- ☐ Argentinean
- ☐ Armenian
- ☐ Asian
- ☐ Asian Indian
- ☐ Assyrian
- ☐ Bangladeshi
- ☐ Barbadian
- ☐ Bhutanese
- ☐ Bolivian
- ☐ Bosnian
- ☐ Brazilian
- ☐ Burmese
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Island
- ☐ Central American
- ☐ Central American Indian
- ☐ Chilean
- ☐ Chinese
- ☐ Columbian
- ☐ Costa Rican
- ☐ Criollo
- ☐ Croation
- ☐ Cuban
- ☐ Dominica Islander
- ☐ Dominican
- ☐ Eastern European
- ☐ Ecuadorian
- ☐ Egyptian
- ☐ English
- ☐ Ethiopian
- ☐ European
- ☐ Filipino
- ☐ French
- ☐ German
- ☐ Ghanian
- ☐ Greek
- ☐ Guatemalan
- ☐ Guyana
- ☐ Haitian
- ☐ Hmong
- ☐ Honduran
- ☐ Indonesian
- ☐ Iranian
- ☐ Iraqi
- ☐ Irish
- ☐ Israeli
- ☐ Italian
- ☐ Iwo Jiman
- ☐ Jamacian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Lebanese
- ☐ Liberian
- ☐ Madagascar
- ☐ Malaysian
- ☐ Maldivian
- ☐ Mexican, Mexican American, Chicano
- ☐ Middle Eastern
- ☐ Nepalese
- ☐ Nicaraguan
- ☐ Nigerian
- ☐ Okinawan
- ☐ Pakistani
- ☐ Palestinian

- ☐ Panamanian
- ☐ Paraguayan
- ☐ Peruvian
- ☐ Polish
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Scottish
- ☐ Sierra Leonian
- ☐ Singaporean
- ☐ Somalian
- ☐ South American Indian
- ☐ Spanish
- ☐ Sri Lankan
- ☐ Syrian
- ☐ Taiwanese
- ☐ Thai
- ☐ Tobagoan
- ☐ Trinidadian
- ☐ Ukranian
- ☐ Unknown/Not Specified
- ☐ Uruguayan
- ☐ Venezuelan
- ☐ Vietamese
- ☐ West Indian
- ☐ Other

1a. If other, list here. _____

2. Do you consider yourself to be Hispanic/Latino(a)?

- ☐ Yes
- ☐ No

3. Which of the following best describes your race? (If the patient asks why we are asking this question or what his/her response has to do with treatment, you can say, "People have a personal opinion about their racial identity. We respect this and ask you to select as many or as few of the options as you wish. We ask this question because some racial groups may not receive all of the support services they need in order to live healthy lives. In order for us to make sure that our hospital does not desciminate on the basis of race, we need to collect this sensitive information from our patients.

- ☐ American Indian/American Native
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other
- ☐ Decline to answer

3a. If other, list here: _____

4. In what language do you prefer to discuss health related concerns?

- ☐ Cantonese
- ☐ Cape Verdian Creole
- ☐ English
- ☐ Haitian Creole
- ☐ Mandarin
- ☐ Portuguese
- ☐ Spanish
- ☐ Other

4a. If other, list here: _____

5. What is the highest grade you completed so far in school? (With children, home visitors should collect infromation on the parent/guardian.)

- ☐ I did not attend school
- ☐ 8th grade or less
- ☐ Some high school
- ☐ Graduated from high school or obtained GED
- ☐ Some college/vocational/technical school
- ☐ Graduated from college, graduate school
- ☐ Other
- ☐ Declined/Unavailable

5a. If other, list here: _____

6. Where did you reach your highest level of education so far?

- ☐ In the U.S.
- ☐ Not in the U.S.
- ☐ Declined/Unavailable

7. Data Collection Comments _____

Act Form Home Visit 1

ACT FORM

Home Visitor: [inspector]
Inspection Date: [inspection_date]
Program ID: [program_id]

How has your/(your child's) asthma been?

Visit number

- ☐ First visit
- ☐ Second visit
- ☐ Third visit
- ☐ Fourth visit
- ☐ Fifth visit
- ☐ Sixth visit
- ☐ 7+ visit

Home Visitor _____

Inspection Date _____

1. What is your relationship to the child?

- ☐ Mother
- ☐ Father
- ☐ Grandparent
- ☐ Aunt/Uncle
- ☐ Guardian
- ☐ Sibling
- ☐ Other

1a. If other, please specify: _____

In the past 4 weeks...

2. How much of the time did asthma keep you/(your child) from getting as much done at work, school or home? (Choose 1)

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

3. How often did you/(your child) have shortness of breath? (Choose 1)

- ☐ More than once per day
- ☐ Once per day
- ☐ 3 to 6 times per week
- ☐ Once or twice per week
- ☐ Not at all

4. How often did your/(your child's) asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you/(them up) at night or earlier than usual in the morning? (Choose 1)

- ☐ 4 or more nights per week
- ☐ 2 or 3 nights per week
- ☐ Once per week
- ☐ Once or twice
- ☐ Not at all

5. How often have you/(your child) used a rescue inhaler or nebulizer medication (such as albuterol)? (Choose 1)

- ☐ 3 or more times per day
- ☐ 1 to 2 times per day
- ☐ 2 or 3 times per week
- ☐ Once per week or less
- ☐ Not at all

6. How would you rate your/(your child's) asthma control? (Choose 1)

- ☐ Not controlled at all
- ☐ Poorly controlled
- ☐ Somewhat controlled
- ☐ Well controlled
- ☐ Completely controlled

7. Total ACT Score (Will populate when you save this form.)

_____

8. Has your child received a flu shot or FluMistTM in the past 12 months?

- ☐ Yes
- ☐ No
- ☐ Last year
- ☐ No, egg allergy
- ☐ Scheduled
- ☐ Parent declines
- ☐ Don't Know

9. In the household, are there OTHER family members who have asthma? (do not include the patient)

- ☐ Yes
- ☐ No

9a. How many?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5+

9b. Who?

- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ Other

9c. If other, please specify:

_____

10. In the past 4 weeks, how many days have you/(your child) slowed down or stopped physical activity due to asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28

(Modified)

11. During the past 6 months, how many work or school days have you or another adult caregiver missed because of your/(their)/(your child's) asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28
- ☐ 29
- ☐ 30
- ☐ over 30
- ☐ Doesn't work/go to school

12. During the past 6 months, how many days has your child missed child care or school because of asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28
- ☐ 29
- ☐ 30
- ☐ over 30
- ☐ N/A

13. During the past 6 months, how many times have you/(your child) been admitted to a hospital overnight because of asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ over 10

14. During the past 6 months, how many times have you/(your child) been to the emergency room because of asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ over 10

15. Besides those emergency room visits during the past 6 months, how many times have you/(your child) gone to the doctor's office or clinic for urgent treatment of worsening asthma symptoms?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ over 10

16. Has your child had any non-urgent (scheduled) asthma visits with the primary care physician, asthma specialist, or asthma nurse in the past 4 weeks?

- ☐ Yes
- ☐ No

16a. How many times?

- ☐ N/A
- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

16b. If so, with whom?

- ☐ Asthma nurse
- ☐ Asthma specialist
- ☐ Primary care physician
- ☐ Other

16b1. If other, please list: _____

17. ACT Form Comments _____

Act Form Home Visit 2

Home Visitor: [home_visitor]
Inspection Date: [inspection_date1]
Program ID: [program_id]

How has your/(your child's) asthma been?

Visit number

- ☐ First visit
- ☐ Second visit
- ☐ Third visit
- ☐ Fourth visit
- ☐ Fifth visit
- ☐ Sixth visit
- ☐ 7+ visit

Home Visitor _____

Inspection Date _____

1. Have you moved since our last visit?

- ☐ Yes
- ☐ No

1a. New zipcode _____

2. What is your relationship to the child?

- ☐ Mother
- ☐ Father
- ☐ Grandparent
- ☐ Aunt/Uncle
- ☐ Guardian
- ☐ Sibling
- ☐ Other

2a. If other, please specify: _____

In the past 4 weeks...

3. How much of the time did asthma keep you/(your child) from getting as much done work, school, or home? (Choose 1)

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

4. How often did you/(your child) have shortness of breath? (Choose 1)

- ☐ More than once per day
- ☐ Once per day
- ☐ 3 to 6 times per week
- ☐ Once or twice per week
- ☐ Not at all

5. How often did you/(your child's) asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you/them up at night or earlier than usual in the morning? (Choose 1)

- ☐ 4 or more nights per week
- ☐ 2 or 3 nights per week
- ☐ Once per week
- ☐ Once or twice
- ☐ Not at all

6. How often have you/(your child) used a rescue inhaler or nebulizer medication (such as albuterol)? (Choose 1)

- ☐ 3 or more times per day
- ☐ 1 to 2 times per day
- ☐ 2 or 3 times per week
- ☐ Once per week or less
- ☐ Not at all

7. How would you rate your/(your child's) asthma control? (Choose 1)

- ☐ Not controlled at all
- ☐ Poorly controlled
- ☐ Somewhat controlled
- ☐ Well controlled
- ☐ Completely controlled

8. Total ACT Score (Will populate when you save this form.)

_____

9. Has your child received a flu shot or FluMistTM since our last visit?

- ☐ Yes
- ☐ No
- ☐ Last year
- ☐ No, egg allergy
- ☐ Scheduled
- ☐ Parent declines
- ☐ Don't Know

10. In the past 4 weeks, how many days have you/(your child) slowed down or stopped physical activity due to asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28

11. Since the last home visit, how many work or school days have you or another adult caregiver missed because of your/(their)/(your child's) asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28
- ☐ 29
- ☐ 30
- ☐ over 30
- ☐ Doesn't work/go to school

12. Since the last home visit, how many days has your child missed child care or school because of asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28
- ☐ 29
- ☐ 30
- ☐ over 30
- ☐ N/A

13. Since the last home visit, how many times have you/(your child) been admitted to a hospital overnight because of asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ over 10

14. Since the last home visit, how many times have you/(your child) been to the emergency room because of asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ over 10

15. Besides those emergency room visits, since our last visit, how many times have you/(your child) gone to the doctor's office or clinic for urgent treatment of worsening asthma symptoms?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ over 10

16. Has your child had any non-urgent (scheduled) asthma visits with the primary care physician, asthma specialist, or asthma nurse in the past 4 weeks?

- ☐ Yes
- ☐ No

16a. How many times?

- ☐ N/A
- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

16b. If so, with whom?

- ☐ Asthma nurse
- ☐ Asthma specialist
- ☐ Primary care physician
- ☐ Other

16c. If other, whom? _____

17. Act Form Comments _____

Act Form Home Visit 3

Home Visitor: [home_visitor1]
Inspection Date: [inspection_date2]
Program ID: [program_id]

How has your/(your child's) asthma been?

Visit number

- ☐ First visit
- ☐ Second visit
- ☐ Third visit
- ☐ Fourth visit
- ☐ Fifth visit
- ☐ Sixth visit
- ☐ 7+ visit

Home Visitor _____

Inspection Date _____

1. Have you moved since last home visit?

- ☐ Yes
- ☐ No

1a. New zipcode _____

2. What is your relationship to the child?

- ☐ Mother
- ☐ Father
- ☐ Grandparent
- ☐ Aunt/Uncle
- ☐ Guardian
- ☐ Sibling
- ☐ Other

If other, please specify: _____

In the past 4 weeks...

3. How much of the time did asthma keep you/(your child) from getting as much done work, school, or home? (Choose 1)

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

4. How often did you/(your child) have shortness of breath? (Choose 1)

- ☐ More than once per day
- ☐ Once per day
- ☐ 3 to 6 times per week
- ☐ Once or twice per week
- ☐ Not at all

5. How often did you/(your child's) asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you/them up at night or earlier than usual in the morning? (Choose 1)

- ☐ 4 or more nights per week
- ☐ 2 or 3 nights per week
- ☐ Once per week
- ☐ Once or twice
- ☐ Not at all

6. How often have you/(your child) used a rescue inhaler or nebulizer medication (such as albuterol)? (Choose 1)

- ☐ 3 or more times per day
- ☐ 1 to 2 times per day
- ☐ 2 or 3 times per week
- ☐ Once per week or less
- ☐ Not at all

7. How would you rate your/(your child's) asthma control? (Choose 1)

- ☐ Not controlled at all
- ☐ Poorly controlled
- ☐ Somewhat controlled
- ☐ Well controlled
- ☐ Completely controlled

8. Total ACT Score (Will populate when you save this form.)

_____

9. Has your child received a flu shot or FluMistTM since our last visit?

- ☐ Yes
- ☐ No
- ☐ Last year
- ☐ No, egg allergy
- ☐ Scheduled
- ☐ Parent declines
- ☐ Don't Know

10. In the past 4 weeks, how many days have you/(your child) slowed down or stopped physical activity due to asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28

11. Since our last visit, how many work or school days have you or another adult caregiver missed because of your/(their)/(your child's) asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28
- ☐ 29
- ☐ 30
- ☐ over 30
- ☐ Doesn't work/go to school

12. Since our last visit, how many days has your child missed child care or school because of asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28
- ☐ 29
- ☐ 30
- ☐ over 30
- ☐ N/A

13. Since our last visit, how many times have you/(your child) been admitted to a hospital overnight because of asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ over 10

14. Since our last visit, how many times have you/(your child) been to the emergency room because of asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ over 10

15. Besides those emergency room visits since our last visit, how many times have you/(your child) gone to the doctor's office or clinic for urgent treatment of worsening asthma symptoms?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ over 10

16. Has your child had any non-urgent (scheduled) asthma visits with the primary care physician, asthma specialist, or asthma nurse in the past 4 weeks?

- ☐ Yes
- ☐ No

16a. How many times?

- ☐ N/A
- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28
- ☐

16b. If so, with whom?

- ☐ Asthma nurse
- ☐ Asthma specialist
- ☐ Primary care physician
- ☐ Other

16c. If other, whom? _____

17. Act Form Comments _____

Asthma Triggers Home Visit 1

ASTHMA TRIGGERS

Home Visitor: [inspector]
Inspection Date: [inspection_date]
Program ID: [program_id]

1. Was allergy testing done?

- ☐ Yes
- ☐ No
- ☐ Dont know

1a. Positive Allergy Testing Results:

- ☐ Animal Dander
- ☐ Cat
- ☐ Dog
- ☐ Dust-mites
- ☐ Feathers
- ☐ Grass
- ☐ Horse
- ☐ Housedust
- ☐ Mice
- ☐ Molds
- ☐ Pollen
- ☐ Roaches
- ☐ Trees
- ☐ Weeds
- ☐ Other

1a1. If other, please specify: _____

If Yes: look back at the referral form to see if allergy testing was done and what they are allergic to.

2. What triggers your/(your child's) asthma?

- ☐ Bleach
- ☐ Chemicals
- ☐ Cockroaches
- ☐ Dust
- ☐ Exercise/ Physical play
- ☐ Illnesses (colds, respiratory infections)
- ☐ Mold
- ☐ Occupational exposures
- ☐ Perfumes/strong detergents
- ☐ Pets/ Animals
- ☐ Pollen
- ☐ Pollution
- ☐ Rodents
- ☐ Tobacco smoke
- ☐ Weather
- ☐ Other
- ☐ Uncertain

2a. If other triggers, please list: _____

3. Is your/(your child's) asthma worse in any particular season?

- ☐ Yes
- ☐ No

3a. If yes, which season(s)?

- ☐ Winter
- ☐ Spring
- ☐ Summer
- ☐ Fall

4. Asthma Triggers Comments _____

Asthma Triggers Home Visit 2

ASTHMA TRIGGERS

Home Visitor: [home_visitor]
Inspection Date: [inspection_date1]
Program ID: [program_id]

1. Was allergy testing done since last visit?

- ☐ Yes
- ☐ No
- ☐ Not Sure

1a. Positive Allergy Testing Results:

- ☐ Animal Dander
- ☐ Cat
- ☐ Dog
- ☐ Dust-mites
- ☐ Feathers
- ☐ Grass
- ☐ Horse
- ☐ Housedust
- ☐ Mice
- ☐ Molds
- ☐ Pollen
- ☐ Roaches
- ☐ Trees
- ☐ Weeds
- ☐ Other

1a1. If other, please specify: _____

2. Asthma Triggers Comments _____

Asthma Triggers Home Visit 3

ASTHMA TRIGGERS

Home Visitor: [home_visitor1]
Inspection Date: [inspection_date2]
Program ID: [program_id]

1. Was allergy testing done since last visit?

- ☐ Yes
- ☐ No
- ☐ Not sure

1a. Positive Allergy Testing Results:

- ☐ Animal Dander
- ☐ Cat
- ☐ Dog
- ☐ Dust-mites
- ☐ Feathers
- ☐ Grass
- ☐ Horse
- ☐ Housedust
- ☐ Mice
- ☐ Molds
- ☐ Pollen
- ☐ Roaches
- ☐ Trees
- ☐ Weeds
- ☐ Other

1a1. If other, please specify: _____

2. Asthma Triggers Comments _____

Asthma Medications Home Visit 1

ASTHMA MEDICATIONS

Home Visitor: [inspector]
Inspection Date: [inspection_date]
Program ID: [program_id]

1. Has your/(your child's) doctor or other health professional provided you with a written plan(Asthma Action Plan) to help you decide how to change your/(your child's) asthma medicine in response to changes in your/(your child's) asthma?

☐ Yes
☐ No
☐ Don't Know

1a. Do you have a copy of the Asthma Action Plan available to show me?

☐ Yes
☐ No

You can lead into this more generally, by having them bring you their medications and then asking to see if they understand the difference between control and quick relief medications, and when they should be administered.

2. Are you/(your child) prescribed any quick-relief medications?

☐ Yes
☐ No

2a. Which medications? (Choose):

☐ Albuterol (MDI) inhaler
☐ Albuterol solution for nebulizer
☐ Atrovent (Ipratropium)
☐ Xopenex (MDI) inhaler or solution

2a1. Albuterol (MDI) inhaler- Dose meter counter (do not include vials in this count)

_____

2a2. Albuterol solution for nebulizer- Number of vials remaining

_____

2a3. Atrovent (Ipratropium) Dose meter counter (do not include vials in this count)

_____

2a4. Atrovent (Ipratropium) Number of vials remaining

_____

2a5. Xopenex (MDI) inhaler or solution - Dose meter counter (do not include vials in this count)

_____

2a6. Xopenex (MDI) inhaler or solution - Number of vials remaining

_____

2b. During the past 14 days (that is, during the past fourteen 24 hour periods that include daytime and nighttime), about how many days did you/(your child) use asthma rescue medicine (sometimes called a quick relief medication) such as albuterol, proventil, ventolin, Xopenex?

_____

2c. When was the last time you/(your child) took them?

_____

3. Are you/ (your child) prescribed any long-term controller medications?

☐ Yes
☐ No

3a. If yes, which?

- ☐ Advair discus
- ☐ Advair MDI inhaler
- ☐ AirDuo
- ☐ Alvesco
- ☐ Asmanex
- ☐ Dulera
- ☐ Flovent
- ☐ Pulmicort flexhaler
- ☐ Pulmicort respules
- ☐ QVAR
- ☐ Singulair
- ☐ Symbicort
- ☐ Other

3b. If other, please specify: _____

3c. During the past 14 days (that is, during the past fourteen 24 hour periods that include daytime and nighttime), about how many days did you/(your child) use asthma controller medicine (sometimes called a preventive medicine or a steroid inhaler) such as QVAR, Pulmicort, Alvesco, Flovent, Asmanex, Symbicort, Advair or Dulera? _____

3d. Flovent dosage?

- ☐ Flovent 44mcg
- ☐ Flovent 110mcg
- ☐ Flovent 220mcg

3d1. How many puffs? (Flovent)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3d2. How many times daily? (Flovent)

- ☐ 1
- ☐ 2
- ☐ 3

3d3. How many doses remaining? _____

3e. Pulmicort respules dosage?

- ☐ Pulmicort respules 0.25mg
- ☐ Pulmicort respules 0.50mg

3e1. How many times daily? (Pulmicort respules)

- ☐ 1
- ☐ 2

3e2. How many doses remaining? _____

3e3. Pulmicort flexhaler dosage?

- ☐ Pulimicort flexhaler 90mcg
- ☐ Pulmicort flexhaler 180mcg

3e4. How many puffs? (Pulmicort flexhaler)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3e5. How many times daily? (Pulmicort flexhaler)

- ☐ 1
- ☐ 2
- ☐ 3

3e6. How many doses remaining? _____

3f. QVAR dosage?

- ☐ QVAR 40mcg
- ☐ QVAR 80mcg

3f1. How many puffs? (QVAR)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3f2. How many times daily? (QVAR)

- ☐ 1
- ☐ 2
- ☐ 3

3f3. How many doses remaining? _____

3g. Advair discus dosage?

- ☐ Advair discus 100/50
- ☐ Advair discus 250/50
- ☐ Advair discus 500/50

3g1. How many puffs? (Advair discus)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3g2. How many times daily? (Advair discus)

- ☐ 1
- ☐ 2
- ☐ 3

3g3. How many doses remaining? _____

3h. Advair MDI inhaler dosage?

- ☐ Advair MDI inhaler 45/21
- ☐ Advair MDI inhaler 115/21
- ☐ Advair MDI inhaler 230/21

3h1. How many puffs? (Advair MDI inhaler)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3h2. How many times daily? (Advair MDI inhaler)

- ☐ 1
- ☐ 2
- ☐ 3

3h3. How many doses remaining? _____

3i. Symbicort dosage?

- ☐ Symbicort 80/4.5
- ☐ Symbicort 160/2.5

3i1. How many puffs? (Symbicort)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3i2. How many times daily? (Symbicort)

- ☐ 1
- ☐ 2
- ☐ 3

3i3. How many doses remaining? _____

3j. Singulair dosage?

- ☐ Singulair 4mg
- ☐ Singulair 5mg
- ☐ Singulair 10mg

3j1. How many doses remaining? _____

3k. Alvesco dosage?

- ☐ Alvesco 80mcg
- ☐ Alvesco 160mcg

3k1. How many puffs? (Alvesco)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3k2. How many times daily? (Alvesco)

- ☐ 1
- ☐ 2
- ☐ 3

3k3. How many doses remaining? _____

3l. Dulera dosage?

- ☐ Dulera 100mcg/5mcg
- ☐ Dulera 200mcg/5mcg

3l1. How many puffs? (Dulera)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3l2. How many times daily? (Dulera)

- ☐ 1
- ☐ 2
- ☐ 3

3l3. How many doses remaining? _____

3m. Asmanex dosage?

- ☐ 110 mcg
- ☐ 220 mcg

3m1. How many puffs? (Asmanex)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3m2. How many times daily? (Asmanex)

- ☐ 1
- ☐ 2

3m3. How many doses remaining? _____

3n. When was the last time you/(your child) took them? _____

3o. AirDuo dosage?

- ☐ AirDuo 55/14
- ☐ AirDuo 113/14
- ☐ AirDuo 232/14

3o1. How many times daily?

- ☐ 1 puff, twice a day
- ☐ Other

3o2. If other, please specify _____

4. Do you/(your child) use any of the following?

- ☐ Dry Powder Inhaler
- ☐ Nebulizer
- ☐ Spacer
- ☐ None

5. Are you/(your child) taking any medications for allergies?

- ☐ Yes
- ☐ No

5a. If yes, which?

- ☐ Benadryl
- ☐ Cetirizine (Zyrtec)
- ☐ Epi-pen/Epi-pen Jr.
- ☐ Fexofenadine (Allegra)
- ☐ loratadine (Claritin)
- ☐ Nasal steroid (Nasonex, Fluticasone, Flonase, Rhinocort, Veramyst, Omnaris, Nasacort)
- ☐ Other

5a1. Nasal steroid dosage?

- ☐ 1 spray in each nostril daily
- ☐ 2 sprays in each nostril daily
- ☐ 1 spray in each nostril twice daily

5a2. Loratadine (Claritin) dosage?

- ☐ 5mg once daily
- ☐ 10mg once daily

5a3. Cetirizine (Zyrtec) dosage?

- ☐ 5mg once daily
- ☐ 10mg once daily

5a4. Fexofenadine (Allegra) dosage?

- ☐ 30mg twice daily
- ☐ 60mg twice daily
- ☐ 180mg twice daily

5a5. Epi-pen expired?

- ☐ Yes
- ☐ No

6. In the last 14 days, how many days have you/ (your child) taken your long-term controller asthma medications?

- ☐ Always
- ☐ Most of the time
- ☐ Sometimes
- ☐ Never
- ☐ Do not take controller medications

Review quick relief and controller medications as needed and go over the Asthma Key Messages regarding medication use.

Observe device technique and correct any problems.

7. Have you ever been unable to or decided not to fill a prescription for an asthma medication?

- ☐ Yes
- ☐ No

7a. If YES, why?

- ☐ Could not afford co-pay
- ☐ Did not understand that needed to keep taking it
- ☐ Do not believe in taking too many meds
- ☐ Do not believe I/my child still needs
- ☐ No insurance
- ☐ No more refills
- ☐ No way to pick up the prescription
- ☐ Prefer to use alternative therapies/home remedies
- ☐ Worried about side effects
- ☐ Other

7a1. If other, please specify: _____

8. Have you/ (your child) been prescribed a course of prednisone (3-5 days, liquid) in the past 6 months, for an asthma episode?

- ☐ Yes
- ☐ No

8a. How many courses?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5+

9. Asthma Medication Comments _____

Asthma Medications Home Visit 2

ASTHMA MEDICATIONS

Home Visitor: [home_visitor]
Inspection Date: [inspection_date1]
Program ID: [program_id]

1. Has your/(your child's) doctor or other health professional provided you with a written plan(Asthma Action Plan) to help you decide how to change your/(your child's) asthma medicine in response to changes in your/(your child's) asthma?

- ☐ Yes
- ☐ No
- ☐ Don't Know

1a. Do you have a copy of the Asthma Action Plan available to show me?

- ☐ Yes
- ☐ No

You can lead into this more generally, by having them bring you their medications and then asking to see if they understand the difference between control and quick relief medications, and when they should be administered.

2. Are you/(your child) prescribed any quick-relief medications?

- ☐ Yes
- ☐ No

2a. Which medications? (Choose):

- ☐ Albuterol (MDI) inhaler
- ☐ Albuterol solution for nebulizer
- ☐ Atrovent (Ipratropium)
- ☐ Xopenex (MDI) inhaler or solution

2a1. Albuterol (MDI) inhaler- Dose meter counter (do not include vials in this count) _____

2a2. Albuterol solution for nebulizer - Number of vials remaining _____

2a3. Atrovent (Ipratropium) Dose meter counter (do not include vials in this count) _____

2a4. Atrovent (Ipratropium) Number of vials remaining _____

2a5. Xopenex (MDI) inhaler or solution - Dose meter counter (do not include vials in this count) _____

2a6. Xopenex (MDI) inhaler or solution - Number of vials remaining _____

2b. During the past 14 days (that is, during the past fourteen 24 hour periods that include daytime and nighttime), about how many days did you/(your child) use asthma rescue medicine (sometimes called a quick relief medication) such as albuterol, proventil, ventolin, Xopenex? _____

2c. When was the last time you/(your child) took them? _____

3. Are you/ (your child) prescribed any long-term controller medications?

- ☐ Yes
- ☐ No

3a. If yes, which?

- ☐ Advair discus
- ☐ Advair MDI inhaler
- ☐ AirDuo
- ☐ Alvesco
- ☐ Asmanex
- ☐ Dulera
- ☐ Flovent
- ☐ Pulmicort flexhaler
- ☐ Pulmicort respules
- ☐ QVAR
- ☐ Singulair
- ☐ Symbicort
- ☐ Other

3b. If other, please specify: _____

3c. During the past 14 days (that is, during the past fourteen 24 hour periods that include daytime and nighttime), about how many days did you/(your child) use asthma controller medicine (sometimes called a preventive medicine or a steroid inhaler) such as QVAR, Pulmicort, Alvesco, Flovent, Asmanex, Symbicort, Advair or Dulera? _____

3d. Flovent dosage?

- ☐ Flovent 44mcg
- ☐ Flovent 110mcg
- ☐ Flovent 220mcg

3d1. How many puffs? (Flovent)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3d2. How many times daily? (Flovent)

- ☐ 1
- ☐ 2
- ☐ 3

3d3. How many doses remaining? _____

3e. Pulmicort respules dosage?

- ☐ Pulmicort respules 0.25mg
- ☐ Pulimicort respules 0.50mg

3e1. How many times daily? (Pulmicort respules)

- ☐ 1
- ☐ 2

3e2. How many doses remaining? _____

3e3. Pulmicort flexhaler dosage?

- ☐ Pulmicort flexhaler 90mcg
- ☐ Pulmicort flexhaler 180mcg

3e4. How many puffs? (Pulmicort flexhaler)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3e5. How many times daily? (Pulmicort flexhaler)

- ☐ 1
- ☐ 2
- ☐ 3

3e6. How many doses remaining? _____

3f. QVAR dosage?

- ☐ QVAR 40mcg
- ☐ QVAR 80mcg

3f1. How many puffs? (QVAR)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3f2. How many times daily? (QVAR)

- ☐ 1
- ☐ 2
- ☐ 3

3f3. How many doses remaining? _____

3g. Advair discus dosage?

- ☐ Advair discus 100/50
- ☐ Advair discus 250/50
- ☐ Advair discus 500/50

3g1. How many puffs? (Advair discus)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3g2. How many times daily? (Advair discus)

- ☐ 1
- ☐ 2
- ☐ 3

3g3. How many doses remaining? _____

3h. Advair MDI inhaler dosage?

- ☐ Advair MDI inhaler 45/21
- ☐ Advair MDI inhaler 115/21
- ☐ Advair MDI inhaler 230/21

3h1. How many puffs? (Advair MDI inhaler)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3h2. How many times daily? (Advair MDI inhaler)

- ☐ 1
- ☐ 2
- ☐ 3

3h3. How many doses remaining? _____

3i. Symbicort dosage?

- ☐ Symbicort 80/4.5
- ☐ Symbicort 160/2.5

3i1. How many puffs? (Symbicort)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3i2. How many times daily? (Symbicort)

- ☐ 1
- ☐ 2
- ☐ 3

3i3. How many doses remaining? _____

3j. Singulair dosage?

- ☐ Singulair 4mg
- ☐ Singulair 5mg
- ☐ Singulair 10mg

3j1. How many doses remaining? _____

3k. Alvesco dosage?

- ☐ Alvesco 80mcg
- ☐ Alvesco 160mcg

3k1. How many puffs? (Alvesco)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3k2. How many times daily? (Alvesco)

- ☐ 1
- ☐ 2
- ☐ 3

3k3. How many doses remaining? _____

3l. Dulera dosage?

- ☐ Dulera 100mcg/5mcg
- ☐ Dulera 200mcg/5mcg

3l1. How many puffs? (Dulera)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3l2. How many times daily? (Dulera)

- ☐ 1
- ☐ 2
- ☐ 3

3l3. How many doses remaining? _____

3m. Asmanex dosage?

- ☐ 110 mcg
- ☐ 220 mcg

3m1. How many puffs? (Asmanex)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3m2. How many times daily? (Asmanex)

- ☐ 1
- ☐ 2

3m3. How many doses remaining? _____

3n. When was the last time you/(your child) took them? _____

3o. AirDuo dosage?

- ☐ AirDuo 55/14
- ☐ AirDuo 113/14
- ☐ AirDuo 232/14

3o1. How many times daily (AirDuo)?

- ☐ 1 puff, twice a day
- ☐ Other

3o2. If other, please specify (AirDuo) _____

4. Do you/(your child) use any of the following?

- ☐ Dry Powder Inhaler
- ☐ Nebulizer
- ☐ Spacer
- ☐ None

5. Are you/(your child) taking any medications for allergies?

- ☐ Yes
- ☐ No

5a. If yes, which?

- ☐ Benadryl
- ☐ Cetirizine (Zyrtec)
- ☐ Epi-pen/Epi-pen Jr.
- ☐ Fexofenadine (Allegra)
- ☐ loratadine (Claritin)
- ☐ Nasal steroid (Nasonex, Fluticasone, Flonase, Rhinocort, Veramyst, Omnaris, Nasacort)
- ☐ Other

5a1. Nasal steroid dosage?

- ☐ 1 spray in each nostril daily
- ☐ 2 sprays in each nostril daily
- ☐ 1 spray in each nostril twice daily

5a2. Loratadine (Claritin) dosage?

- ☐ 5mg once daily
- ☐ 10mg once daily

5a3. Cetirizine (Zyrtec) dosage?

- ☐ 5mg once daily
- ☐ 10mg once daily

5a4. Fexofenadine (Allegra) dosage?

- ☐ 30mg twice daily
- ☐ 60mg twice daily
- ☐ 180mg twice daily

5a5. Epi-pen expired?

- ☐ Yes
- ☐ No

Review quick relief and controller medications as needed and go over the Asthma Key Messages regarding medication use.

Observe device technique and correct any problems.

6. In the last 14 days, how many days have you/ (your child) taken your long-term controller asthma medications?

- ☐ Always
- ☐ Most of the time
- ☐ Sometimes
- ☐ Never
- ☐ Do not take controller medications

7. Have you ever been unable to or decided not to fill a prescription for an asthma medication?

- ☐ Yes
- ☐ No

7a. If YES, why?

- ☐ Could not afford co-pay
- ☐ Did not understand that needed to keep taking it
- ☐ Do not believe in taking too many meds
- ☐ Do not believe I/my child still needs
- ☐ No insurance
- ☐ No more refills
- ☐ No way to pick up the prescription
- ☐ Prefer to use alternative therapies/home remedies
- ☐ Worried about side effects
- ☐ Other

7a1. If other, please specify: _____

8. Have you/ (your child) been prescribed a course of prednisone (3-5 days, liquid) since our last home visit, for an asthma episode?

- ☐ Yes
- ☐ No

8a. How many courses?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5+

9. Asthma Medication Comments _____

Asthma Medications Home Visit 3

ASTHMA MEDICATIONS

Home Visitor: [home_visitor1]
Inspection Date: [inspection_date2]
Program ID: [program_id]

1. Has your/(your child's) doctor or other health professional provided you with a written plan(Asthma Action Plan) to help you decide how to change your/(your child's) asthma medicine in response to changes in your/(your child's) asthma?

- ☐ Yes
- ☐ No
- ☐ Don't Know

1a. Do you have a copy of the Asthma Action Plan available to show me?

- ☐ Yes
- ☐ No

You can lead into this more generally, by having them bring you their medications and then asking to see if they understand the difference between control and quick relief medications, and when they should be administered.

2. Are you/(your child) prescribed any quick-relief medications?

- ☐ Yes
- ☐ No

2a. Which medications? (Select all)

- ☐ Albuterol (MDI) inhaler
- ☐ Albuterol solution for nebulizer
- ☐ Atrovent (Ipratropium)
- ☐ Xopenex (MDI) inhaler or solution

2a1. Albuterol (MDI) inhaler- Dose meter counter (do not include vials in this count) _____

2a2. Albuterol solution for nebulizer- Number of vials remaining _____

2a3. Atrovent (Ipratropium) - Dose meter counter (do not include vials in this count) _____

2a4. Atrovent (Ipratropium) - Number of vials remaining _____

2a5. Xopenex (MDI) inhaler or solution - Dose meter counter (do not include vials in this count) _____

2a6. Xopenex (MDI) inhaler or solution - Number of vials remaining _____

2b. During the past 14 days (that is, during the past fourteen 24 hour periods that include daytime and nighttime), about how many days did you/(your child) use asthma rescue medicine (sometimes called a quick relief medication) such as albuterol, proventil, ventolin, Xopenex? _____

2c. When was the last time you/(your child) took them? _____

3. Are you/ (your child) prescribed any long-term controller medications?

- ☐ Yes
- ☐ No

3a. If yes, which?

- ☐ Advair discus
- ☐ Advair MDI inhaler
- ☐ AirDuo
- ☐ Alvesco
- ☐ Asmanex
- ☐ Dulera
- ☐ Flovent
- ☐ Pulmicort flexhaler
- ☐ Pulmicort respules
- ☐ QVAR
- ☐ Singulair
- ☐ Symbicort
- ☐ Other

3b. If other, please specify: _____

3c. During the past 14 days (that is, during the past fourteen 24 hour periods that include daytime and nighttime), about how many days did you/(your child) use asthma controller medicine (sometimes called a preventive medicine or a steroid inhaler) such as QVAR, Pulmicort, Alvesco, Flovent, Asmanex, Symbicort, Advair or Dulera? _____

3d. Flovent dosage?

- ☐ Flovent 44mcg
- ☐ Flovent 110mcg
- ☐ Flovent 220mcg

3d1. How many puffs? (Flovent)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3d2. How many times daily? (Flovent)

- ☐ 1
- ☐ 2
- ☐ 3

3d3. How many doses remaining? _____

3e. Pulmicort respules dosage?

- ☐ Pulmicort respules 0.25mg
- ☐ Pulimicort respules 0.50mg

3e1. How many times daily? (Pulmicort respules)

- ☐ 1
- ☐ 2

3e2. How many doses are remaining? _____

3e3. Pulmicort flexhaler dosage?

- ☐ Pulmicort flexhaler 90mcg
- ☐ Pulmicort flexhaler 180mcg

3e4. How many puffs? (Pulmicort flexhaler)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3e5. How many times daily? (Pulmicort flexhaler)

- ☐ 1
- ☐ 2
- ☐ 3

3e6. How many doses are remaining? _____

3f. QVAR dosage?

- ☐ QVAR 40mcg
- ☐ QVAR 80mcg

3f1. How many puffs? (QVAR)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3f2. How many times daily? (QVAR)

- ☐ 1
- ☐ 2
- ☐ 3

3f3. How many doses are remaining? _____

3g. Advair discus dosage?

- ☐ Advair discus 100/50
- ☐ Advair discus 250/50
- ☐ Advair discus 500/50

3g1. How many puffs? (Advair discus)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3g2. How many times daily? (Advair discus)

- ☐ 1
- ☐ 2
- ☐ 3

3g3. How many doses are remaining? _____

3h. Advair MDI inhaler dosage?

- ☐ Advair MDI inhaler 45/21
- ☐ Advair MDI inhaler 115/21
- ☐ Advair MDI inhaler 230/21

3h1. How many puffs? (Advair MDI inhaler)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3h2. How many times daily? (Advair MDI inhaler)

- ☐ 1
- ☐ 2
- ☐ 3

3h3. How many doses are remaining? _____

3i. Symbicort dosage?

- ☐ Symbicort 80/4.5
- ☐ Symbicort 160/2.5

3i1. How many puffs? (Symbicort)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3i2. How many times daily? (Symbicort)

- ☐ 1
- ☐ 2
- ☐ 3

3i3. How many doses are remaining? _____

3j. Singulair dosage?

- ☐ Singulair 4mg
- ☐ Singulair 5mg
- ☐ Singulair 10mg

3j1. How many doses remaining? _____

3k. Alvesco dosage?

- ☐ Alvesco 80mcg
- ☐ Alvesco 160mcg

3k1. How many puffs? (Alvesco)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3k2. How many times daily? (Alvesco)

- ☐ 1
- ☐ 2
- ☐ 3

3k3. How many doses remaining? _____

3l. Dulera dosage?

- ☐ Dulera 100mcg/5mcg
- ☐ Dulera 200mcg/5mcg

3l1. How many puffs? (Dulera)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3l2. How many times daily? (Dulera)

- ☐ 1
- ☐ 2
- ☐ 3

3l3. How many doses remaining? _____

3m. Asmanex dosage?

- ☐ 110 mcg
- ☐ 220 mcg

3m1. How many puffs? (Asmanex)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

3m2. How many times daily? (Asmanex)

- ☐ 1
- ☐ 2

3m3. How many doses remaining? _____

3n. When was the last time you/(your child) took them? _____

3o. AirDuo dosage?

- ☐ AirDuo 55/14
- ☐ AirDuo 113/14
- ☐ AirDuo 232/14

3o1. How many times daily?

- ☐ 1 puff, twice a day
- ☐ Other

3o2. If other, please specify _____

4. Do you/(your child) use any of the following?

- ☐ Dry Powder Inhaler
- ☐ Nebulizer
- ☐ Spacer
- ☐ None

5. Are you/(your child) taking any medications for allergies?

- ☐ Yes
- ☐ No

5a. If yes, which?

- ☐ Benadryl
- ☐ Cetirizine (Zyrtec)
- ☐ Epi-pen/Epi-pen Jr.
- ☐ Fexofenadine (Allegra)
- ☐ Loratadine (Claritin)
- ☐ Nasal steroid (Nasonex, Fluticasone, Flonase, Rhinocort, Veramyst, Omnaris, Nasacort)
- ☐ Other

5a1. Nasal steroid dosage?

- ☐ 1 spray in each nostril daily
- ☐ 2 sprays in each nostril daily
- ☐ 1 spray in each nostril twice daily

5a2. Loratadine (Claritin) dosage?

- ☐ 5mg once daily
- ☐ 10mg once daily

5a3. Cetirizine (Zyrtec) dosage?

- ☐ 5mg once daily
- ☐ 10mg once daily

5a4. Fexofenadine (Allegra) dosage?

- ☐ 30mg twice daily
- ☐ 60mg twice daily
- ☐ 180mg twice daily

5a5. Epi-pen expired?

- ☐ Yes
- ☐ No

Review quick relief and controller medications as needed and go over the Asthma Key Messages regarding medication use.

Observe device technique and correct any problems.

6. In the last 14 days, how many days have you/ your child taken your controller asthma medications?

- ☐ Always
- ☐ Most of the time
- ☐ Sometimes
- ☐ Never
- ☐ Do not take controller medications

7. Have you ever been unable to or decided not to fill a prescription for an asthma medication?

- ☐ Yes
- ☐ No

7a. If YES, why?

- ☐ Could not afford co-pay
- ☐ Did not understand that needed to keep taking it
- ☐ Do not believe in taking too many meds
- ☐ Do not believe I/my child still needs
- ☐ No insurance
- ☐ No more refills
- ☐ No way to pick up the prescription
- ☐ Prefer to use alternative therapies/home remedies
- ☐ Worried about side effects
- ☐ Other

7a1. If other, please specify: _____

8. Have you/ (your child) been prescribed a course of prednisone (3-5 days, liquid) since our last home visit, for an asthma episode?

- ☐ Yes
- ☐ No

8a. How many courses?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5+

9. Asthma Medication Comments _____

Resident Report Home Visit 1

RESIDENT REPORT

Home Visitor: [inspector]
Inspection Date: [inspection_date]
Program ID: [program_id]

For situations where parents are separated, tenancy question(s) should be about that respective parent's household. If a child lives in other's parent's house a majority of the time, then attempt to do a home visit there, too.

1. Type of Tenancy
- ☐ Own House
- ☐ Renting; Privately Owned
- ☐ Renting; Managed Apartment
- ☐ Public Housing
- ☐ Shelter
- ☐ Subsidized Housing
- ☐ Other

1a. If other type of tenancy, please specify: _____

2. Floors lived in (check all that apply)
- ☐ Basement
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

3. Mold and Moisture In the past 30 days has anyone seen or smelled mold or a musty odor inside your home? (Emphasize in the past 30 days)
- ☐ Yes
- ☐ No

3a. If yes, please specify location: _____

3a1. What evidence of mold have you found?
- ☐ Musty Odor Evident
- ☐ Visible water/mold damage

4. Do you use any of the following (check all that apply)
- ☐ Dehumidifier
- ☐ Vaporizer or humidifier
- ☐ don't use either

5. Do you have furry or feathered pets, such as dogs, cats, rabbits, birds, hamsters/gerbils/other rodents, or others?
- ☐ Yes
- ☐ No

5a. What kind of pet(s)?
- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

5b. If other, please specify: _____

5a1. Number of bird(s)
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a2. Number of cats

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a3. Number of dogs

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a4. Number of rodent(s)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a5. Number of other

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5c. Pet Management (Check all that apply)

- ☐ Kept strictly outdoors
- ☐ Not allowed in bedroom
- ☐ Allowed in your/(your child's) sleeping area
- ☐ Sleeps in your/(your child's) sleeping area
- ☐ Full access in home

6. Cockroaches (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

6a. If evidence in other, please specify where: _____

7. Mice (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

7a. If evidence in other, please specify where: _____

8. Do you have any of the following chemicals in your home that have a strong odor or that irritates your/(your child's) asthma or makes the asthma worse, such as:

- ☐ Air fresheners, scented candles, incense, or potpourri
- ☐ Cleaning products that contain bleach or ammonia
- ☐ Paint products, solvents, or glue
- ☐ Pesticides
- ☐ Other irritants (strong odors such as hairspray, cooking fumes, etc.)
- ☐ Other strong cleaners
- ☐ None
- ☐ Don't Know

8a. If other strong cleaners are used, please specify: _____

9. What type of pesticide(s) do you use? (check all that apply)

- ☐ Gel Baits
- ☐ Smoke bombs foggers
- ☐ Sprays
- ☐ Traps
- ☐ Other
- ☐ None/ Don't use pesticides

9a. If pesticide not listed, please type here. _____

9b. Where are Pesticides Stored? (Check all that Apply)

- ☐ Bathroom
- ☐ Kitchen
- ☐ Other

9c. If other, where do you store your pesticides? _____

10. Which of the following do you use to clean your home? (Check all that apply)

- ☐ Damp mop
- ☐ Dry mop
- ☐ Dusting
- ☐ HEPA vacuum
- ☐ Standard vacuum (non HEPA)
- ☐ Sweep
- ☐ Swiffer
- ☐ Other

10a. If other, what else do you use to clean? _____

11. Heat fuel used (check all that apply)

- ☐ Electric
- ☐ Natural gas/LPG
- ☐ Oil
- ☐ Wood
- ☐ Other
- ☐ None

11a. If other heat fuel source, please specify: _____

12. Heating sources in home (check all that apply)

- ☐ Baseboards
- ☐ Forced warm air
- ☐ Radiators
- ☐ Space heater or oven
- ☐ Other

12a. If other, please specify: _____

12b. Have the filters been changed or cleaned in the past year?

- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ N/A - no filters

13. Is the heat easy to control or hard to control?

- ☐ Easy to control
- ☐ Hard to control

14. What do you use for cooling? (Check all that apply.)

- ☐ Central/Window AC
- ☐ Fans
- ☐ Windows
- ☐ None

15. What do you use for ventilation? (Check all that apply.)

- ☐ Central ventilation
- ☐ HEPA air filter
- ☐ Kitchen/bathroom fans
- ☐ Open windows
- ☐ None

16. Does anyone living in the home smoke?

- ☐ Yes
- ☐ No

16a. How many people smoke (including yourself)?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5+

16b. Who in the home smokes (Check all that apply)?

- ☐ Father
- ☐ Grandparent(s)
- ☐ Guardian
- ☐ Mother
- ☐ Sibling(s)
- ☐ Yourself
- ☐ Other

16b1. Please specify: _____

16c. Where do you/they smoke?

- ☐ Smoke inside
- ☐ Smoke outside
- ☐ Smoke both inside and outside

17. Where else is your child exposed to smoke?

- ☐ At the home of other family/friends
- ☐ From outside
- ☐ Inside another building
- ☐ Inside the building but not in the home
- ☐ Other
- ☐ Not exposed

17a. If other, list places other than those mentioned where you/your child is exposed to smoke: _____

18. Are you (or anyone else in the home) interested in quitting smoking?

- ☐ Yes
- ☐ No

Opportunity to discuss Quitworks other resources for tobacco cessation and the Smoke Free Home Pledge.

19. Referred to Quitworks?

- ☐ Yes
- ☐ No

20. Resident Report Comments _____

Secondary Home Resident Report Home Visit 1

Secondary Household Resident Report

1. Is this the child's secondary household?
- ☐ Yes
- ☐ No

Please continue answering the following questions.

1a. Type of Tenancy
- ☐ Own House
- ☐ Renting; Privately Owned
- ☐ Renting; Managed Apartment
- ☐ Public Housing
- ☐ Shelter
- ☐ Subsidized Housing
- ☐ Other

1a1. If other type of tenancy, please specify: _____

2. Floors lived in (check all that apply)
- ☐ Basement
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

3. Mold and Moisture In the past 30 days has anyone seen or smelled mold or a musty odor inside your home? (Emphasize in the past 30 days)
- ☐ Yes
- ☐ No

3a. If yes, please specify location: _____

3a1. What evidence of mold have you found?
- ☐ Musty Odor Evident
- ☐ Visible water/mold damage

4. Do you use any of the following (check all that apply)
- ☐ Dehumidifier
- ☐ Vaporizer or humidifier
- ☐ No, don't use either

5. Do you have furry or feathered pets, such as dogs, cats, rabbits, birds, hamsters/gerbils/other rodents, or others?
- ☐ Yes
- ☐ No

5a. What kind of pet(s)?
- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

5b. If other, please specify: _____

5a1. Number of Bird(s)
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a2. Number of cats
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a3. Number of dogs

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a4. Number of rodent(s)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a5. Number of other

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5c. Pet Management (Check all that apply)

- ☐ Kept strictly outdoors
- ☐ Not allowed in bedroom
- ☐ Allowed in your/(your child's) sleeping area
- ☐ Sleeps in your/(your child's) sleeping area
- ☐ Full access in home

6. Cockroaches (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

6a. If evidence in other, please specify where: _____

7. Mice (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

7a. If evidence in other, please specify where: _____

8. Do you have any of the following chemicals in your home that have a strong odor or that irritates your/(your child's) asthma or makes the asthma worse, such as:

- ☐ Air fresheners, scented candles, incense, or potpourri
- ☐ Cleaning products that contain bleach or ammonia
- ☐ Paint products, solvents, or glue
- ☐ Pesticides
- ☐ Other irritants (strong odors such as hairspray, cooking fumes, etc.)
- ☐ Other strong cleaners
- ☐ None
- ☐ Don't Know

8a. If other strong cleaners are used, please specify: _____

9. What type of pesticide(s) do you use? (check all that apply)

- ☐ Gel Baits
- ☐ Smoke bombs foggers
- ☐ Sprays
- ☐ Traps
- ☐ Other
- ☐ None/ Don't use pesticides

9a. If pesticide not listed, please type here. _____

9b. Where are Pesticides Stored? (Check all that Apply)

- ☐ Bathroom
- ☐ Kitchen
- ☐ Other

9c. If other, where do you store your pesticides? _____

10. Which of the following do you use to clean your home? (Check all that apply)

- ☐ Damp mop
- ☐ Dry mop
- ☐ Dusting
- ☐ HEPA vacuum
- ☐ Standard vacuum (non HEPA)
- ☐ Sweep
- ☐ Swiffer
- ☐ Other

10a. If other, what else do you use to clean? _____

11. Heat fuel used (check all that apply)

- ☐ Electric
- ☐ Natural gas/LPG
- ☐ Oil
- ☐ Wood
- ☐ Other
- ☐ None

11a. If other heat fuel source, please specify: _____

12. Heating sources in home (check all that apply)

- ☐ Baseboards
- ☐ Forced warm air
- ☐ Radiators
- ☐ Space heater or oven
- ☐ Other

12a. If other, please specify: _____

12b. Have the filters been changed or cleaned in the past year?

- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ N/A - no filters

13. Is the heat easy to control or hard to control?

- ☐ Easy to control
- ☐ Hard to control

14. What do you use for cooling? (Check all that apply.)

- ☐ Central/Window AC
- ☐ Fans
- ☐ Windows
- ☐ None

15. What do you use for ventilation? (Check all that apply.)

- ☐ Central ventilation
- ☐ HEPA air filter
- ☐ Kitchen/bathroom fans
- ☐ Open windows
- ☐ None

16. Does anyone living in the home smoke?

- ☐ Yes
- ☐ No

16a. How many people smoke (including yourself)?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5+

16b. Who in the home smokes (Check all that apply)?

- ☐ Father
- ☐ Grandparent(s)
- ☐ Guardian
- ☐ Mother
- ☐ Sibling(s)
- ☐ Yourself
- ☐ Other

16b1. Please specify: _____

16c. Where do you/they smoke?

- ☐ Smoke inside
- ☐ Smoke outside
- ☐ Smoke both inside and outside

17. Where else is your child exposed to smoke?

- ☐ At the home of other family/friends
- ☐ From outside
- ☐ Inside another building
- ☐ Inside the building but not in the home
- ☐ Other
- ☐ Not exposed

17a. If other, list places other than those mentioned where you/your child is exposed to smoke: _____

18. Are you (or anyone else in the home) interested in quitting smoking?

- ☐ Yes
- ☐ No

Opportunity to discuss Quitworks other resources for tobacco cessation and the Smoke Free Home Pledge.

19. Referred to Quitworks?

- ☐ Yes
- ☐ No

20. Resident Report Comments _____

Resident Report Home Visit 2

RESIDENT REPORT

Home Visitor: [home_visitor]
Inspection Date: [inspection_date1]
Program ID: [program_id]

For situations where parents are separated, tenancy question(s) should be about that respective parent's household. If a child lives in other's parent's house a majority of the time, then attempt to do a home visit there, too.

1. Type of Tenancy
- ☐ Own House
- ☐ Renting; Privately Owned
- ☐ Renting; Managed Apartment
- ☐ Public Housing
- ☐ Shelter
- ☐ Subsidized Housing
- ☐ Other

1a. If other type of tenancy, please specify: _____

2. Floors lived in (check all that apply)
- ☐ Basement
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

3. Mold and Moisture In the past 30 days has anyone seen or smelled mold or a musty odor inside your home? (Emphasize in the past 30 days)
- ☐ Yes
- ☐ No

3a. If yes, please specify location: _____

3a1. What evidence of mold have you found?
- ☐ Musty Odor Evident
- ☐ Visible water/mold damage

4. Do you use any of the following (check all that apply)
- ☐ Dehumidifier
- ☐ Vaporizer or humidifier
- ☐ No, don't use either

5. Do you have furry or feathered pets, such as dogs, cats, rabbits, birds, hamsters/gerbils/other rodents, or others?
- ☐ Yes
- ☐ No

5a. What kind of pet?
- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

5b. If other, please specify: _____

5a1. Number of bird(s)
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a2. Number of cats

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a3. Number of dogs

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a4. Number of rodents

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a5. Number of other

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5c. Pet Management (Check all that apply)

- ☐ Kept strictly outdoors
- ☐ Not allowed in bedroom
- ☐ Allowed in your/(your child's) sleeping area
- ☐ Sleeps in your/(your child's) sleeping area
- ☐ Full access in home

6. Cockroaches (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

6a. If evidence in other, please specify where: _____

7. Mice (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

7a. If evidence in other, please specify where: _____

8. Do you have any of the following chemicals in your home that have a strong odor or that irritates your/(your child's) asthma or makes the asthma worse, such as:

- ☐ Air fresheners, scented candles, incense, or potpourri
- ☐ Cleaning products that contain bleach or ammonia
- ☐ Paint products, solvents, or glue
- ☐ Pesticides
- ☐ Other irritants (strong odors such as hairspray, cooking fumes, etc.)
- ☐ Other strong cleaners
- ☐ None
- ☐ Don't Know

8a. If other strong cleaners are used, please specify: _____

9. What type of pesticide(s) do you use? (check all that apply)

- ☐ Gel Baits
- ☐ Smoke bombs foggers
- ☐ Sprays
- ☐ Traps
- ☐ None/ I don't use pesticides
- ☐ Other

9a. If pesticide not listed, please type here. _____

9b. Where are Pesticides Stored? (Check all that Apply)

- ☐ Bathroom
- ☐ Kitchen
- ☐ Other

9c. If other, where do you store your pesticides? _____

10. Which of the following do you use to clean your home? (Check all that apply)

- ☐ Damp mop
- ☐ Dry mop
- ☐ Dusting
- ☐ HEPA vacuum
- ☐ Standard vacuum (non HEPA)
- ☐ Sweep
- ☐ Swiffer
- ☐ Other

10a. If other, what else do you use to clean? _____

11. Heat fuel used (check all that apply)

- ☐ Electric
- ☐ Natural gas/LPG
- ☐ Oil
- ☐ Wood
- ☐ Other
- ☐ None

11a. If other heat fuel source, please specify: _____

12. Heating sources in home (check all that apply)

- ☐ Baseboards
- ☐ Forced warm air
- ☐ Radiators
- ☐ Space heater or oven
- ☐ Other

12a. If other, please specify: _____

12b. Have the filters been changed or cleaned in the past year?

- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ N/A - no filters

13. Is the heat easy to control or hard to control?

- ☐ Easy to control
- ☐ Hard to control

14. What do you use for cooling? (Check all that apply.)

- ☐ Central/Window AC
- ☐ Fans
- ☐ Windows
- ☐ None

15. What do you use for ventilation? (Check all that apply.)

- ☐ Central ventilation
- ☐ HEPA air filter
- ☐ Kitchen/bathroom fans
- ☐ Open windows
- ☐ None

16. Does anyone living in the home smoke?

- ☐ Yes
- ☐ No

16a. How many people smoke (including yourself)?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5+

16b. Who in the home smokes (Check all that apply)?

- ☐ Father
- ☐ Grandparent(s)
- ☐ Guardian
- ☐ Mother
- ☐ Sibling(s)
- ☐ Yourself
- ☐ Other

16b1. Please specify: _____

16c. Where do you/they smoke?

- ☐ Smoke inside
- ☐ Smoke outside
- ☐ Smoke both inside and outside

17. Where else is your child exposed to smoke?

- ☐ At the home of other family/friends
- ☐ From outside
- ☐ Inside another building
- ☐ Inside the building but not in the home
- ☐ Other
- ☐ Not exposed

17a. If other, list places other than those mentioned where you/your child is exposed to smoke: _____

18. Are you (or anyone else in the home) interested in quitting smoking?

- ☐ Yes
- ☐ No

Opportunity to discuss Quitworks other resources for tobacco cessation and the Smoke Free Home Pledge.

19. Referred to Quitworks?

- ☐ Yes
- ☐ No

20. Resident Report Comments _____

Secondary Home Resident Report Home Visit 2

Secondary Household Resident Report

1. Is this the child's secondary household?
- ☐ Yes
- ☐ No

Please continue answering the following questions.

1a. Type of Tenancy
- ☐ Own House
- ☐ Renting; Privately Owned
- ☐ Renting; Managed Apartment
- ☐ Public Housing
- ☐ Shelter
- ☐ Subsidized Housing
- ☐ Other

1a1. If other type of tenancy, please specify: _____

2. Floors lived in (check all that apply)
- ☐ Basement
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

3. Mold and Moisture In the past 30 days has anyone seen or smelled mold or a musty odor inside your home? (Emphasize in the past 30 days)
- ☐ Yes
- ☐ No

3a. If yes, please specify location: _____

3a1. What evidence of mold have you found?
- ☐ Musty Odor Evident
- ☐ Visible water/mold damage

4. Do you use any of the following (check all that apply)
- ☐ Dehumidifier
- ☐ Vaporizer or humidifier
- ☐ No, don't use either

5. Do you have furry or feathered pets, such as dogs, cats, rabbits, birds, hamsters/gerbils/other rodents, or others?
- ☐ Yes
- ☐ No

5a. What kind of pet?
- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

5b. If other, please specify: _____

5a1. Number of bird(s)
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a2. Number of cats
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a3. Number of dogs

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a4. Number of rodent(s)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a5. Number of other

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5c. Pet Management (Check all that apply)

- ☐ Kept strictly outdoors
- ☐ Not allowed in bedroom
- ☐ Allowed in your/(your child's) sleeping area
- ☐ Sleeps in your/(your child's) sleeping area
- ☐ Full access in home

6. Cockroaches (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

6a. If evidence in other, please specify where: _____

7. Mice (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

7a. If evidence in other, please specify where: _____

8. Do you have any of the following chemicals in your home that have a strong odor or that irritates your/ (your child's) asthma or makes the asthma worse, such as:

- ☐ Air fresheners, scented candles, incense, or potpourri
- ☐ Cleaning products that contain bleach or ammonia
- ☐ Paint products, solvents, or glue
- ☐ Pesticides
- ☐ Other irritants (strong odors such as hairspray, cooking fumes, etc.)
- ☐ Other strong cleaners
- ☐ None
- ☐ Don't Know

8a. If other strong cleaners are used, please specify: _____

9. What type of pesticide(s) do you use? (check all that apply)

- ☐ Gel Baits
- ☐ Smoke bombs foggers
- ☐ Sprays
- ☐ Traps
- ☐ None/ I don't use pesticides
- ☐ Other

9a. If pesticide not listed, please type here. _____

9b. Where are Pesticides Stored? (Check all that Apply)

- ☐ Bathroom
- ☐ Kitchen
- ☐ Other

9c. If other, where do you store your pesticides? _____

10. Which of the following do you use to clean your home? (Check all that apply)
- ☐ Damp mop
- ☐ Dry mop
- ☐ Dusting
- ☐ HEPA vacuum
- ☐ Standard vacuum (non HEPA)
- ☐ Sweep
- ☐ Swiffer
- ☐ Other

10a. If other, what else do you use to clean? _____

11. Heat fuel used (check all that apply)
- ☐ Electric
- ☐ Natural gas/LPG
- ☐ Oil
- ☐ Wood
- ☐ Other
- ☐ None

11a. If other heat fuel source, please specify: _____

12. Heating sources in home (check all that apply)
- ☐ Baseboards
- ☐ Forced warm air
- ☐ Radiators
- ☐ Space heater or oven
- ☐ Other

12a. If other, please specify: _____

12b. Have the filters been changed or cleaned in the past year?
- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ N/A - no filters

13. Is the heat easy to control or hard to control?
- ☐ Easy to control
- ☐ Hard to control

14. What do you use for cooling? (Check all that apply.)
- ☐ Central/Window AC
- ☐ Fans
- ☐ Windows
- ☐ None

15. What do you use for ventilation? (Check all that apply.)
- ☐ Central ventilation
- ☐ HEPA air filter
- ☐ Kitchen/bathroom fans
- ☐ Open windows
- ☐ None

16. Do you smoke?
- ☐ Yes
- ☐ No

16a. Does anyone else living in the home smoke?
- ☐ Yes
- ☐ No

16b. How many people smoke (including yourself)?
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5+

16c. Who in the home smokes (Check all that apply)?
- ☐ Father
- ☐ Mother
- ☐ Grandparent(s)
- ☐ Sibling(s)
- ☐ Yourself
- ☐ Other

16c1. Please specify: _____

16d. Where do you/they smoke?

- ☐ Smoke inside
- ☐ Smoke outside
- ☐ Smoke both inside and outside

17. Where is your child exposed to smoke?

- ☐ At the home of other family/friends
- ☐ From outside
- ☐ Inside another building
- ☐ Inside the building but not in the home
- ☐ Other\
- ☐ Not exposed

17a. If other, list places other than those mentioned where you/your child is exposed to smoke: _____

18. Are you (or anyone else in the home) interested in quitting smoking?

- ☐ Yes
- ☐ No

Opportunity to discuss Quitworks other resources for tobacco cessation and the Smoke Free Home Pledge.

19. Referred to Quitworks?

- ☐ Yes
- ☐ No

20. Resident Report Comments _____

Resident Report Home Visit 3

RESIDENT REPORT

Home Visitor: [home_visitor1]
Inspection Date: [inspection_date2]
Program ID: [program_id]

For situations where parents are separated, tenancy question(s) should be about that respective parent's household. If a child lives in other's parent's house a majority of the time, then attempt to do a home visit there, too.

1. Type of Tenancy
- ☐ Own House
- ☐ Renting; Privately Owned
- ☐ Renting; Managed Apartment
- ☐ Public Housing
- ☐ Shelter
- ☐ Subsidized Housing
- ☐ Other

1a. If other type of tenancy, please specify: _____

2. Floors lived in (check all that apply)
- ☐ Basement
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

3. Mold and Moisture In the past 30 days has anyone seen or smelled mold or a musty odor inside your home? (Emphasize in the past 30 days)
- ☐ Yes
- ☐ No

3a. If yes, please specify location(s): _____

3a1. What evidence of mold have you found?
- ☐ Musty Odor Evident
- ☐ Visible water/mold damage

4. Do you use any of the following (check all that apply)
- ☐ Dehumidifier
- ☐ Vaporizer or humidifier
- ☐ No, don't use either

5. Do you have furry or feathered pets, such as dogs, cats, rabbits, birds, hamsters/gerbils/other rodents, or others?
- ☐ Yes
- ☐ No

5a. What kind of pet?
- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

5b. If other, please specify: _____

5a1. Number of bird(s)
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a2. Number of cats

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a3. Number of dogs

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a4. Number of rodent(s)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a5. Number of other

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5c. Pet Management (Check all that apply)

- ☐ Kept strictly outdoors
- ☐ Not allowed in bedroom
- ☐ Allowed in your/(your child's) sleeping area
- ☐ Sleeps in your/(your child's) sleeping area
- ☐ Full access in home

6. Cockroaches (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

6a. If evidence in other, please specify where: _____

7. Mice (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

7a. If evidence in other, please specify where: _____

8. Do you have any of the following chemicals in your home that have a strong odor or that irritates your/(your child's) asthma or makes the asthma worse, such as:

- ☐ Air fresheners, scented candles, incense, or potpourri
- ☐ Cleaning products that contain bleach or ammonia
- ☐ Paint products, solvents, or glue
- ☐ Pesticides
- ☐ Other irritants (strong odors such as hairspray, cooking fumes, etc.)
- ☐ Other strong cleaners
- ☐ None
- ☐ Don't Know

8a. If other strong cleaners are used, please specify: _____

9. What type of pesticide(s) do you use? (check all that apply)

- ☐ Gel Baits
- ☐ Smoke bombs foggers
- ☐ Sprays
- ☐ Traps
- ☐ None/ I don't use pesticides
- ☐ Other

9a. If pesticide not listed, please type here. _____

9b. Where are Pesticides Stored? (Check all that Apply)

- ☐ Bathroom
- ☐ Kitchen
- ☐ Other

9c. If other, where do you store your pesticides? _____

10. Which of the following do you use to clean your home? (Check all that apply)

- ☐ Damp mop
- ☐ Dry mop
- ☐ Dusting
- ☐ HEPA vacuum
- ☐ Standard vacuum (non HEPA)
- ☐ Sweep
- ☐ Swiffer
- ☐ Other

10a. If other, what else do you use to clean? _____

11. Heat fuel used (check all that apply)

- ☐ Electric
- ☐ Natural gas/LPG
- ☐ Oil
- ☐ Wood
- ☐ Other
- ☐ None

11a. If other heat fuel source, please specify: _____

12. Heating sources in home (check all that apply)

- ☐ Baseboards
- ☐ Forced warm air
- ☐ Radiators
- ☐ Space heater or oven
- ☐ Other

12a. If other, please specify: _____

12b. Have the filters been changed or cleaned in the past year?

- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ N/A - no filters

13. Is the heat easy to control or hard to control?

- ☐ Easy to control
- ☐ Hard to control

14. What do you use for cooling? (Check all that apply.)

- ☐ Central/Window AC
- ☐ Fans
- ☐ Windows
- ☐ None

15. What do you use for ventilation? (Check all that apply.)

- ☐ Central ventilation
- ☐ HEPA air filter
- ☐ Kitchen/bathroom fans
- ☐ Open windows
- ☐ None

16. Does anyone living in the home smoke?

- ☐ Yes
- ☐ No

16a. How many people smoke (including yourself)?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5+

16b. Who in the home smokes (Check all that apply)?

- ☐ Father
- ☐ Grandparent(s)
- ☐ Guardian
- ☐ Mother
- ☐ Sibling(s)
- ☐ Yourself
- ☐ Other

16b1. Please specify: _____

16c. Where do you/they smoke?

- ☐ Smoke inside
- ☐ Smoke outside
- ☐ Smoke both inside and outside

17. Where else is your child exposed to smoke?

- ☐ At the home of other family/friends
- ☐ From outside
- ☐ Inside another building
- ☐ Inside the building but not in the home
- ☐ Other
- ☐ Not exposed

17a. If other, list places other than those mentioned where you/your child is exposed to smoke: _____

18. Are you (or anyone else in the home) interested in quitting smoking?

- ☐ Yes
- ☐ No

Opportunity to discuss Quitworks other resources for tobacco cessation and the Smoke Free Home Pledge.

19. Referred to Quitworks?

- ☐ Yes
- ☐ No

20. Resident Report Comments _____

Secondary Home Resident Report Home Visit 3

Secondary Household Resident Report

1. Is this the child's secondary household?
- ☐ Yes
- ☐ No

Please continue answering the following questions.

1a. Type of Tenancy
- ☐ Own House
- ☐ Renting; Privately Owned
- ☐ Renting; Managed Apartment
- ☐ Public Housing
- ☐ Shelter
- ☐ Subsidized Housing
- ☐ Other

1a1. If other type of tenancy, please specify: _____

2. Floors lived in (check all that apply)
- ☐ Basement
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

3. Mold and Moisture In the past 30 days has anyone seen or smelled mold or a musty odor inside your home? (Emphasize in the past 30 days)
- ☐ Yes
- ☐ No

3a. If yes, please specify location(s): _____

3a1. What evidence of mold have you found?
- ☐ Musty Odor Evident
- ☐ Visible water/mold damage

4. Do you use any of the following (check all that apply)
- ☐ Dehumidifier
- ☐ Vaporizer or humidifier
- ☐ No, don't use either

5. Do you have furry or feathered pets, such as dogs, cats, rabbits, birds, hamsters/gerbils/other rodents, or others?
- ☐ Yes
- ☐ No

5a. What kind of pet?
- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

5b. If other, please specify: _____

5a1. Number of bird(s)
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a2. Number of cats
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a3. Number of dogs

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a4. Number of rodent(s)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5a5. Number of other

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4+

5c. Pet Management (Check all that apply)

- ☐ Kept strictly outdoors
- ☐ Not allowed in bedroom
- ☐ Allowed in your/(your child's) sleeping area
- ☐ Sleeps in your/(your child's) sleeping area
- ☐ Full access in home

6. Cockroaches (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

6a. If evidence in other, please specify where: _____

7. Mice (Check all that apply)

- ☐ None - reports/see no evidence
- ☐ Reports/see evidence in kitchen
- ☐ Reports/see evidence in bedroom
- ☐ Reports/see evidence in other

7a. If evidence in other, please specify where: _____

8. Do you have any of the following chemicals in your home that have a strong odor or that irritates your/ (your child's) asthma or makes the asthma worse, such as:

- ☐ Air fresheners, scented candles, incense, or potpourri
- ☐ Cleaning products that contain bleach or ammonia
- ☐ Paint products, solvents, or glue
- ☐ Pesticides
- ☐ Other irritants (strong odors such as hairspray, cooking fumes, etc.)
- ☐ Other strong cleaners
- ☐ None
- ☐ Don't Know

8a. If other strong cleaners are used, please specify: _____

9. What type of pesticide(s) do you use? (check all that apply)

- ☐ Gel Baits
- ☐ Smoke bombs foggers
- ☐ Sprays
- ☐ Traps
- ☐ None/ I don't use pesticides
- ☐ Other

9a. If pesticide not listed, please type here. _____

9b. Where are Pesticides Stored? (Check all that Apply)

- ☐ Bathroom
- ☐ Kitchen
- ☐ Other

9c. If other, where do you store your pesticides? _____

10. Which of the following do you use to clean your home? (Check all that apply)

- ☐ Damp mop
- ☐ Dry mop
- ☐ Dusting
- ☐ HEPA vacuum
- ☐ Standard vacuum (non HEPA)
- ☐ Sweep
- ☐ Swiffer
- ☐ Other

10a. If other, what else do you use to clean? _____

11. Heat fuel used (check all that apply)

- ☐ Electric
- ☐ Natural gas/LPG
- ☐ Oil
- ☐ Wood
- ☐ Other
- ☐ None

11a. If other heat fuel source, please specify: _____

12. Heating sources in home (check all that apply)

- ☐ Baseboards
- ☐ Forced warm air
- ☐ Radiators
- ☐ Space heater or oven
- ☐ Other

12a. If other, please specify: _____

12b. Have the filters been changed or cleaned in the past year?

- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ N/A - no filters

13. Is the heat easy to control or hard to control?

- ☐ Easy to control
- ☐ Hard to control

14. What do you use for cooling? (Check all that apply.)

- ☐ Central/Window AC
- ☐ Fans
- ☐ Windows
- ☐ None

15. What do you use for ventilation? (Check all that apply.)

- ☐ Central ventilation
- ☐ HEPA air filter
- ☐ Kitchen/bathroom fans
- ☐ Open windows
- ☐ None

16. Does anyone living in the home smoke?

- ☐ Yes
- ☐ No

16a. How many people smoke (including yourself)?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5+

16b. Who in the home smokes (Check all that apply)?

- ☐ Father
- ☐ Grandparent(s)
- ☐ Guardian
- ☐ Mother
- ☐ Sibling(s)
- ☐ Yourself
- ☐ Other

16b1. Please specify: _____

16c. Where do you/they smoke?

- ☐ Smoke inside
- ☐ Smoke outside
- ☐ Smoke both inside and outside

17. Where else is your child exposed to smoke?

- ☐ At the home of other family/friends
- ☐ From outside
- ☐ Inside another building
- ☐ Inside the building but not in the home
- ☐ Other
- ☐ Not exposed

17a. If other, list places other than those mentioned where you/your child is exposed to smoke: _____

18. Are you (or anyone else in the home) interested in quitting smoking?

- ☐ Yes
- ☐ No

Opportunity to discuss Quitworks other resources for tobacco cessation and the Smoke Free Home Pledge.

19. Referred to Quitworks?

- ☐ Yes
- ☐ No

20. Resident Report Comments _____

Home Visit 1 Observations

HOME VISIT OBSERVATIONS

Home Visitor: [inspector]
Inspection Date: [inspection_date]
Program ID: [program_id]

Please identify triggers present in the specified rooms.

1. Kitchen (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dishes in sink
- ☐ Dust
- ☐ Food debris
- ☐ Grease on stove
- ☐ Mold growth present
- ☐ Rodents
- ☐ Trash or garbage not sealed
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

1a. Is there an exhaust fan?

- ☐ Yes
- ☐ No

2. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

2a. Is it vented outside?

- ☐ Yes
- ☐ No
- ☐ Don't know

3. Bathroom (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ No window present
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/maintenance
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

3a. Is there an exhaust fan in the bathroom?

- ☐ Yes
- ☐ No

3b. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

4. Living room (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/ maintenance
- ☐ Rodents
- ☐ Soiling
- ☐ Wall/ ceiling/ floor damage
- ☐ No triggers identified

5. Laundry area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dryer not vented outside
- ☐ Dust
- ☐ Food debris
- ☐ Hang clothes to dry
- ☐ Mold growth present
- ☐ Not well maintained
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified
- ☐ No laundry area

****All remaining questions are for PATIENT'S SLEEPING AREA ONLY****

6. Patient's sleeping area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Other sleeping situation
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

7. Does the patient share a room?

- ☐ Yes
- ☐ No
- ☐ N/A

7a. Shared number in room (include patient in count)

- ☐ 2
- ☐ 3
- ☐ 4+

7b. Number of beds in patient's sleeping area

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ More than 2

8. Allergen impermeable encasings on beds

- ☐ On mattress (zippered)
- ☐ On mattress (not zippered)
- ☐ No mattress encasement
- ☐ On box spring (zippered)
- ☐ On box spring (not zippered)
- ☐ No box spring
- ☐ Pillow covers
- ☐ No pillow covers

9. Flooring (note: for patient's sleeping area only)

- ☐ Hardwood
- ☐ Large area rug
- ☐ Linoleum
- ☐ Small area rug
- ☐ Tile
- ☐ Wall to wall carpet

10. Dust/ Mold catchers (note: for patient's sleeping area only)

- ☐ Non-washable toys
- ☐ Plants
- ☐ Stuffed animals
- ☐ Washable toys
- ☐ Other
- ☐ None

10a. If other, please specify: _____

11. Windows (note: for patient's sleeping area only)

- ☐ Curtains/ drapes
- ☐ Washable blinds
- ☐ Washable shades/curtains
- ☐ No window/ poor ventilation

12. Do you see any evidence of smoking in the home?

- ☐ Yes
- ☐ No

12a. If yes, what evidence?

- ☐ See smoking paraphernalia
- ☐ Smell smoke
- ☐ Other

12b. If other, please specify: _____

13. Home Visit Observations Comments _____

Secondaryhome Home Visit 1 Observations

Secondary Home

Home Observations

Is this the child's secondary household?

- ☐ Yes
- ☐ No

Please continue answering the following questions.

1. Kitchen (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dishes in sink
- ☐ Dust
- ☐ Food debris
- ☐ Grease on stove
- ☐ Mold growth present
- ☐ Rodents
- ☐ Trash or garbage not sealed
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

1a. Is there an exhaust fan?

- ☐ Yes
- ☐ No

2. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

2a. Is it vented outside?

- ☐ Yes
- ☐ No
- ☐ Don't Know

3. Bathroom (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ No window present
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/maintenance
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

3a. Is there an exhaust fan in the bathroom?

- ☐ Yes
- ☐ No

3b. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

4. Living room (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/ maintenance
- ☐ Rodents
- ☐ Soiling
- ☐ Wall/ ceiling/ floor damage
- ☐ No triggers identified

5. Laundry area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dryer not vented outside
- ☐ Dust
- ☐ Food debris
- ☐ Hang clothes to dry
- ☐ Mold growth present
- ☐ Not well maintained
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

****All remaining questions are for PATIENT'S SLEEPING AREA ONLY****

6. Patient's sleeping area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Other sleeping situation
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

7. Does the patient share a room?

- ☐ Yes
- ☐ No
- ☐ N/A

7a. Shared number in room (include patient in count)

- ☐ 2
- ☐ 3
- ☐ 4+

7b. Number of beds in patient's sleeping area

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ More than 2

8. Allergen impermeable encasings on beds

- ☐ On mattress (zippered)
- ☐ On mattress (not zippered)
- ☐ No mattress encasement
- ☐ On box spring (zippered)
- ☐ On box spring (not zippered)
- ☐ No box spring
- ☐ Pillow covers
- ☐ No pillow covers

9. Flooring (note: for patient's sleeping area only)

- ☐ Hardwood
- ☐ Large area rug
- ☐ Linoleum
- ☐ Small area rug
- ☐ Tile
- ☐ Wall to wall carpet

10. Dust/ Mold catchers (note: for patient's sleeping area only)

- ☐ Non-washable toys
- ☐ Plants
- ☐ Stuffed animals
- ☐ Washable toys
- ☐ Other
- ☐ None

10a. If other, please specify: _____

11. Windows (note: for patient's sleeping area only)

- ☐ Curtains/ drapes
- ☐ Washable blinds
- ☐ Washable shades/curtains
- ☐ No window/ poor ventilation

12. Do you see any evidence of smoking in the home?

- ☐ Yes
- ☐ No

12a. If yes, what evidence?

- ☐ See smoking paraphernalia
- ☐ Smell smoke
- ☐ Other

12b. If other, please specify: _____

13. Home Visit Observations Comments _____

Home Visit 2 Observations

HOME VISIT OBSERVATIONS

Home Visitor: [home_visitor]
Inspection Date: [inspection_date1]
Program ID: [program_id]

1. Kitchen (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dishes in sink
- ☐ Dust
- ☐ Food debris
- ☐ Grease on stove
- ☐ Mold growth present
- ☐ Rodents
- ☐ Trash or garbage not sealed
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

1a. Is there an exhaust fan?

- ☐ Yes
- ☐ No

2. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

2a. Is it vented outside?

- ☐ Yes
- ☐ No
- ☐ Don't know

3. Bathroom (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/maintenance
- ☐ No window present
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

3a. Is there an exhaust fan in the bathroom?

- ☐ Yes
- ☐ No

3b. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

4. Living room (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/ maintenance
- ☐ Rodents
- ☐ Soiling
- ☐ Wall/ ceiling/ floor damage
- ☐ No triggers identified

5. Laundry area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dryer not vented outside
- ☐ Dust
- ☐ Food debris
- ☐ Hang clothes to dry
- ☐ Mold growth present
- ☐ Not well maintained
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified
- ☐ No laundry area

****All remaining questions are for PATIENT'S SLEEPING AREA ONLY****

6. Patient's sleeping area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Other sleeping situation
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

7. Does the patient share a room?

- ☐ Yes
- ☐ No
- ☐ N/A

7a. Shared number in room (include patient in count)

- ☐ 2
- ☐ 3
- ☐ 4+

7b. Number of beds in patient's sleeping area

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ More than 2

8. Allergen impermeable encasings on beds

- ☐ On mattress (zippered)
- ☐ On mattress (not zippered)
- ☐ No mattress encasement
- ☐ On box spring (zippered)
- ☐ On box spring (not zippered)
- ☐ No box spring
- ☐ Pillow covers
- ☐ No pillow covers

9. Flooring (note: for patient's sleeping area only)

- ☐ Hardwood
- ☐ Large area rug
- ☐ Linoleum
- ☐ Small area rug
- ☐ Tile
- ☐ Wall to wall carpet

10. Dust/ Mold catchers (note: for patient's sleeping area only)

- ☐ Non-washable toys
- ☐ Plants
- ☐ Stuffed animals
- ☐ Washable toys
- ☐ Other
- ☐ None

10a. If other, please specify: _____

11. Windows (note: for patient's sleeping area only)

- ☐ Curtains/ drapes
- ☐ Washable blinds
- ☐ Washable shades/curtains
- ☐ No window/ poor ventilation

12. Do you see any evidence of smoking in the home?

- ☐ Yes
- ☐ No

12a. If yes, what evidence?

- ☐ See smoking paraphernalia
- ☐ Smell smoke
- ☐ Other

12b. If other, please specify: _____

13. Home Visit Observations Comments _____

Secondaryhome Home Visit 2 Observations

HOME VISIT OBSERVATIONS

Home Visitor: [home_visitor]
Inspection Date: [inspection_date1]
Program ID: [program_id]

Secondary Household
Home Observations

Is this the child's secondary household?

- ☐ Yes
- ☐ No

Please continue answering the following questions.

1. Kitchen (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dishes in sink
- ☐ Dust
- ☐ Food debris
- ☐ Grease on stove
- ☐ Mold growth present
- ☐ Rodents
- ☐ Trash or garbage not sealed
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

1a. Is there an exhaust fan?

- ☐ Yes
- ☐ No

2. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

2a. Is it vented outside?

- ☐ Yes
- ☐ No
- ☐ Don't know

3. Bathroom (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/maintenance
- ☐ No window present
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

3a. Is there an exhaust fan in the bathroom?

- ☐ Yes
- ☐ No

3b. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

4. Living room (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/ maintenance
- ☐ Rodents
- ☐ Soiling
- ☐ Wall/ ceiling/ floor damage
- ☐ No triggers identified

5. Laundry area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dryer not vented outside
- ☐ Dust
- ☐ Food debris
- ☐ Hang clothes to dry
- ☐ Mold growth present
- ☐ Not well maintained
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified
- ☐ No laundry area

****All remaining questions are for PATIENT'S SLEEPING AREA ONLY****

6. Patient's sleeping area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Other sleeping situation
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

7. Does the patient share a room?

- ☐ Yes
- ☐ No
- ☐ N/A

7a. Shared number in room (include patient in count)

- ☐ 2
- ☐ 3
- ☐ 4+

7b. Number of beds in patient's sleeping area

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ More than 2

8. Allergen impermeable encasings on beds

- ☐ On mattress (zippered)
- ☐ On mattress (not zippered)
- ☐ No mattress encasement
- ☐ On box spring (zippered)
- ☐ On box spring (not zippered)
- ☐ No box spring
- ☐ Pillow covers
- ☐ No pillow covers

9. Flooring (note: for patient's sleeping area only)

- ☐ Hardwood
- ☐ Large area rug
- ☐ Linoleum
- ☐ Small area rug
- ☐ Tile
- ☐ Wall to wall carpet

10. Dust/ Mold catchers (note: for patient's sleeping area only)

- ☐ Non-washable toys
- ☐ Plants
- ☐ Stuffed animals
- ☐ Washable toys
- ☐ Other
- ☐ None

10a. If other, please specify: _____

11. Windows (note: for patient's sleeping area only)

- ☐ Curtains/ drapes
- ☐ Washable blinds
- ☐ Washable shades/curtains
- ☐ No window/ poor ventilation

12. Do you see any evidence of smoking in the home?

- ☐ Yes
- ☐ No

12a. If yes, what evidence?

- ☐ See smoking paraphernalia
- ☐ Smell smoke
- ☐ Other

12b. If other, please specify: _____

13. Home Visit Observations Comments _____

Home Visit 3 Observations

HOME VISIT OBSERVATIONS

Home Visitor: [home_visitor1]
Inspection Date: [inspection_date2]
Program ID: [program_id]

1. Kitchen (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dishes in sink
- ☐ Dust
- ☐ Food debris
- ☐ Grease on stove
- ☐ Mold growth present
- ☐ Rodents
- ☐ Trash or garbage not sealed
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

1a. Is there an exhaust fan?

- ☐ Yes
- ☐ No

2. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

2a. Is it vented outside?

- ☐ Yes
- ☐ No
- ☐ Don't know

3. Bathroom (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/maintenance
- ☐ No window present
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

3a. Is there an exhaust fan in the bathroom?

- ☐ Yes
- ☐ No

3b. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

4. Living room (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/ maintenance
- ☐ Rodents
- ☐ Soiling
- ☐ Wall/ ceiling/ floor damage
- ☐ No triggers identified

5. Laundry area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dryer not vented outside
- ☐ Dust
- ☐ Food debris
- ☐ Hang clothes to dry
- ☐ Mold growth present
- ☐ Not well maintained
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified
- ☐ No laundry area

****All remaining questions are for PATIENT'S SLEEPING AREA ONLY****

6. Patient's sleeping area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Other sleeping situation
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

7. Does the patient share a room?

- ☐ Yes
- ☐ No
- ☐ N/A

7a. Shared number in room (include patient in count)

- ☐ 2
- ☐ 3
- ☐ 4+

7b. Number of beds in patient's sleeping area

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ More than 2

8. Allergen impermeable encasings on beds

- ☐ On mattress (zippered)
- ☐ On mattress (not zippered)
- ☐ No mattress encasement
- ☐ On box spring (zippered)
- ☐ On box spring (not zippered)
- ☐ No box spring
- ☐ Pillow covers
- ☐ No pillow covers

9. Flooring (note: for patient's sleeping area only)

- ☐ Hardwood
- ☐ Large area rug
- ☐ Linoleum
- ☐ Small area rug
- ☐ Tile
- ☐ Wall to wall carpet

10. Dust/ Mold catchers (note: for patient's sleeping area only)

- ☐ Non-washable toys
- ☐ Plants
- ☐ Stuffed animals
- ☐ Washable toys
- ☐ Other
- ☐ None

10a. If other, please specify: _____

11. Windows (note: for patient's sleeping area only)

- ☐ Curtains/ drapes
- ☐ Washable blinds
- ☐ Washable shades/curtains
- ☐ No window/ poor ventilation

12. Do you see any evidence of smoking in the home?

- ☐ Yes
- ☐ No

12a. If yes, what evidence?

- ☐ See smoking paraphernalia
- ☐ Smell smoke
- ☐ Other

12b. If other, please specify: _____

13. Home Visit Observations Comments _____

Secondaryhome Home Visit 3 Observations

Secondary Household Home Observations

Is this the child's secondary household?

- ☐ Yes
- ☐ No

Please continue answering the following questions.

1. Kitchen (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dishes in sink
- ☐ Dust
- ☐ Food debris
- ☐ Grease on stove
- ☐ Mold growth present
- ☐ Rodents
- ☐ Trash or garbage not sealed
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

1a. Is there an exhaust fan?

- ☐ Yes
- ☐ No

2. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

2a. Is it vented outside?

- ☐ Yes
- ☐ No
- ☐ Don't know

3. Bathroom (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Cleaning products with bleach or ammonia
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/maintenance
- ☐ No window present
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

3a. Is there an exhaust fan in the bathroom?

- ☐ Yes
- ☐ No

3b. Does exhaust fan function properly?

- ☐ Yes
- ☐ No

4. Living room (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Needs cleaning/ maintenance
- ☐ Rodents
- ☐ Soiling
- ☐ Wall/ ceiling/ floor damage
- ☐ No triggers identified

5. Laundry area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dryer not vented outside
- ☐ Dust
- ☐ Food debris
- ☐ Hang clothes to dry
- ☐ Mold growth present
- ☐ Not well maintained
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified
- ☐ No laundry area

****All remaining questions are for PATIENT'S SLEEPING AREA ONLY****

6. Patient's sleeping area (Check all that apply)

- ☐ Abundant cosmetics and fragrances
- ☐ Clutter
- ☐ Cockroaches
- ☐ Dust
- ☐ Food debris
- ☐ Mold growth present
- ☐ Other sleeping situation
- ☐ Rodents
- ☐ Wall/ceiling/floor damage
- ☐ No triggers identified

7. Does the patient share a room?

- ☐ Yes
- ☐ No
- ☐ N/A

7a. Shared number in room (include patient in count)

- ☐ 2
- ☐ 3
- ☐ 4+

7b. Number of beds in patient's sleeping area

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ More than 2

8. Allergen impermeable encasings on beds

- ☐ On mattress (zippered)
- ☐ On mattress (not zippered)
- ☐ No mattress encasement
- ☐ On box spring (zippered)
- ☐ On box spring (not zippered)
- ☐ No box spring
- ☐ Pillow covers
- ☐ No pillow covers

9. Flooring (note: for patient's sleeping area only)

- ☐ Hardwood
- ☐ Large area rug
- ☐ Linoleum
- ☐ Small area rug
- ☐ Tile
- ☐ Wall to wall carpet

10. Dust/ Mold catchers (note: for patient's sleeping area only)

- ☐ Non-washable toys
- ☐ Plants
- ☐ Stuffed animals
- ☐ Washable toys
- ☐ Other
- ☐ None

10a. If other, please specify: _____

11. Windows (note: for patient's sleeping area only)

- ☐ Curtains/ drapes
- ☐ Washable blinds
- ☐ Washable shades/curtains
- ☐ No window/ poor ventilation

12. Do you see any evidence of smoking in the home?

- ☐ Yes
- ☐ No

12a. If yes, what evidence?

- ☐ See smoking paraphernalia
- ☐ Smell smoke
- ☐ Other

12b. If other, please specify: _____

13. Home Visit Observations Comments _____

Progress Report Home Visit 1

PROGRESS REPORT

Home Visitor: [inspector]
Inspection Date: [inspection_date]
Program ID: [program_id]

Asthma Control

1. ACT Score [q6_totalactscore]

(20-25 Well Controlled
16-19 Not Well-Controlled
0-15 Poorly Controlled)

2. Limitations in Activity
☐ Yes
☐ No

3. Recent ER visit in last 6 months ?
☐ Yes
☐ No

3a. If yes, then how many? _____

4. Recent admission in last 6 months?
☐ Yes
☐ No

4a. If yes, how many? _____

5. Asthma Action Plan Present
☐ Yes
☐ No

6. Medications all present
☐ Yes
☐ No

7. Is client adhering to their medication(s)?
☐ Yes
☐ No

8. Understand quick relief v. controller
☐ Yes
☐ No

9. Spacer present
☐ Yes
☐ No

10. Med Interventions
☐ Barriers to adherence (See comments)
☐ Call for refills
☐ Clarified current meds with clinic
☐ Contacted clinic for updated AAP
☐ Device demonstration repeat demo
☐ Go back to PCP for maintenance
☐ Review role/proper meds dosing
☐ Other

10a1. Please specify: _____

10a. Specify other _____

Environmental Triggers: Initial/Ongoing Issues

****Check whether it's an issue****

11. Cockroaches
- ☐ Yes
- ☐ No

11a. Status of cockroach issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

12. Rodents
- ☐ Yes
- ☐ No

12a. Status of rodents issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

13. Mold
- ☐ Yes
- ☐ No

13a. Status of mold issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

14. Dust/clutter/stuffed animals
- ☐ Yes
- ☐ No

14a. Status of Dust/clutter/stuffed animals
- ☐ Severe
- ☐ Moderate
- ☐ Mild

15. Unsanitary conditions
- ☐ Yes
- ☐ No

15a. Status of unsanitary conditions is
- ☐ Severe
- ☐ Moderate
- ☐ Mild

16. Carpeting
- ☐ Yes
- ☐ No

17. Environmental smoke
- ☐ Yes
- ☐ No

17a. If yes, please specify (check all that apply):
- ☐ Hookah
- ☐ Marijuana
- ☐ Tobacco
- ☐ Other
- ☐ Not sure

17a1. If other, please list/specify: _____

18. Strong cleaners VOCs
- ☐ Yes
- ☐ No

19. Pets
- ☐ Yes
- ☐ No

19a. What kind of pets?
- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

19a1. If other, please specify: _____

20. Other Environmental Triggers
- ☐ Yes
- ☐ No

20a. Other _____

21. Supplies provided
- ☐ Encasings- Mattress and Pillow
- ☐ HEPA Vacuum
- ☐ Integrated Pest Management Kit
- ☐ Other

21a. Specify Other _____

22. Referrals made
- ☐ Asthma Swim Program
- ☐ Breathe Easy - ISD
- ☐ Quitworks - smoking cessation service
- ☐ Other

22a. Specify Other _____

23. Recommendations
- ☐ Conduct Allergy Test
- ☐ Green cleaning
- ☐ Integrated pest management education
- ☐ Reduce clutter
- ☐ Remove pet from bedroom/home
- ☐ Smoke free home pledge
- ☐ Tobacco counseling
- ☐ Vacuum/dust/wash bedding weekly
- ☐ Work order/contact landlord re: violations
- ☐ Other

23a. Specify other _____

24. Progress Report Comments _____

Secondary Home Progress Report Home Visit 1

Secondary Household Progress Report

1. Is this the child's secondary household?
- ☐ Yes
- ☐ No

Please continue answering the following questions.

2. Limitations in Activity
- ☐ Yes
- ☐ No

3. Recent ER visit in last 6 months ?
- ☐ Yes
- ☐ No

3a. If yes, then how many? _____

4. Recent admission in last 6 months?
- ☐ Yes
- ☐ No

4a. If yes, how many? _____

5. Asthma Action Plan Present
- ☐ Yes
- ☐ No

6. Medications all present
- ☐ Yes
- ☐ No

7. Is client adhering to their medication(s)?
- ☐ Yes
- ☐ No

8. Understand quick relief v. controller
- ☐ Yes
- ☐ No

9. Spacer present
- ☐ Yes
- ☐ No

10. Med Interventions
- ☐ Barriers to adherence (See comments)
- ☐ Call for refills
- ☐ Clarified current meds with clinic
- ☐ Contacted clinic for updated AAP
- ☐ Device demonstration repeat demo
- ☐ Go back to PCP for maintenance
- ☐ Review role/proper meds dosing
- ☐ Other

10a1. Please specify: _____

10a. Specify other _____

11. Cockroaches
- ☐ Yes
- ☐ No

11a. Status of cockroach issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

12. Rodents
- ☐ Yes
- ☐ No

12a. Status of rodents issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

13. Mold
- ☐ Yes
- ☐ No

13a. Status of mold issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

14. Dust/clutter/stuffed animals
- ☐ Yes
- ☐ No

14a. Status of Dust/clutter/stuffed animals
- ☐ Severe
- ☐ Moderate
- ☐ Mild

15. Unsanitary conditions
- ☐ Yes
- ☐ No

15a. Status of unsanitary conditions is
- ☐ Severe
- ☐ Moderate
- ☐ Mild

16. Carpeting
- ☐ Yes
- ☐ No

17. Environmental smoke
- ☐ Yes
- ☐ No

17a. If yes, please specify (check all that apply):
- ☐ Hookah
- ☐ Marijuana
- ☐ Tobacco
- ☐ Other
- ☐ Not sure

17a1. If other, please list/specify: _____

18. Strong cleaners VOCs
- ☐ Yes
- ☐ No

19. Pets
- ☐ Yes
- ☐ No

19a. What kind of pets?
- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

19a1. If other, please specify: _____

20. Other Environmental Triggers
- ☐ Yes
- ☐ No

20a. Other _____

21. Supplies provided
- ☐ Encasings- Mattress and Pillow
- ☐ HEPA Vacuum
- ☐ Integrated Pest Management Kit
- ☐ Other

21a. Specify Other _____

22. Referrals made

- ☐ Asthma Swim Program
- ☐ Breathe Easy - ISD
- ☐ Quitworks - smoking cessation service
- ☐ Other

22a. Specify Other _____

23. Recommendations

- ☐ Conduct Allergy Test
- ☐ Green cleaning
- ☐ Integrated pest management education
- ☐ Reduce clutter
- ☐ Remove pet from bedroom/home
- ☐ Smoke free home pledge
- ☐ Tobacco counseling
- ☐ Vacuum/dust/wash bedding weekly
- ☐ Work order/contact landlord re: violations
- ☐ Other

23a. Specify other _____

24. Progress Report Comments _____

Progress Report Home Visit 2

PROGRESS REPORT

Home Visitor: [home_visitor]
Inspection Date: [inspection_date1]
Program ID: [program_id]

Asthma Control

1. ACT Score: [act_totalscore]
(20-25 Well Controlled
16-19 Not Well-Controlled
0-15 Poorly Controlled)

2. Limitations in Activity
☐ Yes
☐ No

3. Recent ER visit since last home visit ?
☐ Yes
☐ No

3a. If yes, then how many? _____

4. Recent admission since last home visit?
☐ Yes
☐ No

4a. If yes, how many? _____

5. Asthma Action Plan Present
☐ Yes
☐ No

6. Medications all present
☐ Yes
☐ No

7. Is client adhering to their medication(s)?
☐ Yes
☐ No

8. Understand quick relief v. controller
☐ Yes
☐ No

9. Spacer present
☐ Yes
☐ No

10. Med Interventions
☐ Barriers to adherence (See comments)
☐ Call for refills
☐ Clarified current meds with clinic
☐ Contacted clinic for updated AAP
☐ Device demonstration repeat demo
☐ Go back to PCP for maintenance
☐ Review role/proper meds dosing
☐ Other

10a1. Please specify: _____

10a. Specify other _____

Environmental Triggers: Initial/Ongoing Issues

Check whether it's an issue

11. Cockroaches
- ☐ Yes
- ☐ No
- ☐ Resolved

11a. Status of cockroach issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

12. Rodents
- ☐ Yes
- ☐ No
- ☐ Resolved

12a. Status of rodents issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

13. Mold
- ☐ Yes
- ☐ No
- ☐ Resolved

13a. Status of mold issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

14. Dust/clutter/stuffed animals
- ☐ Yes
- ☐ No
- ☐ Resolved

14a. Status of dust/clutter/stuffed animals:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

15. Unsanitary conditions
- ☐ Yes
- ☐ No
- ☐ Resolved

15a. Status of unsanitary conditions is
- ☐ Severe
- ☐ Moderate
- ☐ Mild

16. Carpeting
- ☐ Yes
- ☐ No
- ☐ Resolved

17. Environmental smoke
- ☐ Yes
- ☐ No
- ☐ Resolved

17a. If yes, please specify (check all that apply):
- ☐ Hookah
- ☐ Marijuana
- ☐ Tobacco
- ☐ Other
- ☐ Not sure

18. Strong cleaners (VOCs)
- ☐ Yes
- ☐ No
- ☐ Resolved

18a. Status of strong cleaners [VOCs]:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

19. Pets
- ☐ Yes
- ☐ No
- ☐ Resolved

19a. What kind of pets?
- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

19a1. If other, please specify: _____

19a2. Are pet(s) allowed in patient's bedroom?
- ☐ Yes
- ☐ No

20. Other Environmental Triggers
- ☐ Yes
- ☐ No
- ☐ Resolved

20a. Other _____

21. Supplies provided
- ☐ Encasings- Mattress and Pillow
- ☐ HEPA Vacuum
- ☐ Integrated Pest Management Kit
- ☐ Other

21a. Specify Other _____

22. Referrals made
- ☐ Asthma Swim Program
- ☐ Breathe Easy - ISD
- ☐ Quitworks - smoking cessation service
- ☐ Other

22a. Specify Other _____

23. Recommendations
- ☐ Conduct Allergy Test
- ☐ Green cleaning
- ☐ Integrated pest management education
- ☐ Reduce clutter
- ☐ Remove pet from bedroom/home
- ☐ Smoke free home pledge
- ☐ Tobacco counseling
- ☐ Vacuum/dust/wash bedding weekly
- ☐ Work order/contact landlord re: violations
- ☐ Other

23a. Specify other _____

24. Progress Report Comments _____

Secondary Home Progress Report Home Visit 2

Secondary Household Progress Report

1. Is this the child's secondary household?
- ☐ Yes
- ☐ No

Please continue answering the following questions.

2. Limitations in Activity
- ☐ Yes
- ☐ No

3. Recent ER visit since last home visit ?
- ☐ Yes
- ☐ No

3a. If yes, then how many? _____

4. Recent admission since last home visit?
- ☐ Yes
- ☐ No

4a. If yes, how many? _____

5. Asthma Action Plan Present
- ☐ Yes
- ☐ No

6. Medications all present
- ☐ Yes
- ☐ No

7. Is client adhering to their medication(s)?
- ☐ Yes
- ☐ No

8. Understand quick relief v. controller
- ☐ Yes
- ☐ No

9. Spacer present
- ☐ Yes
- ☐ No

10. Med Interventions
- ☐ Barriers to adherence (See comments)
- ☐ Call for refills
- ☐ Clarified current meds with clinic
- ☐ Contacted clinic for updated AAP
- ☐ Device demonstration repeat demo
- ☐ Go back to PCP for maintenance
- ☐ Review role/proper meds dosing
- ☐ Other

10a1. Please specify: _____

10a. Specify other _____

11. Cockroaches
- ☐ Yes
- ☐ No
- ☐ Resolved

11a. Status of cockroach issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

12. Rodents
- ☐ Yes
- ☐ No
- ☐ Resolved

12a. Status of rodents issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

13. Mold
- ☐ Yes
- ☐ No
- ☐ Resolved

13a. Status of mold issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

14. Dust/clutter/stuffed animals
- ☐ Yes
- ☐ No
- ☐ Resolved

14a. Status of dust/clutter/stuffed animals
- ☐ Severe
- ☐ Moderate
- ☐ Mild

15. Unsanitary conditions
- ☐ Yes
- ☐ No
- ☐ Resolved

15a. Status of unsanitary conditions is
- ☐ Severe
- ☐ Moderate
- ☐ Mild

16. Carpeting
- ☐ Yes
- ☐ No
- ☐ Resolved

17. Environmental smoke
- ☐ Yes
- ☐ No
- ☐ Resolved

17a. If yes, please specify (check all that apply):
- ☐ Hookah
- ☐ Marijuana
- ☐ Tobacco
- ☐ Other
- ☐ Not sure

18. Strong cleaners VOCs
- ☐ Yes
- ☐ No
- ☐ Resolved

18a. Status of strong cleaners (VOCs)
- ☐ Severe
- ☐ Moderate
- ☐ Mild

19. Pets
- ☐ Yes
- ☐ No
- ☐ Resolved

19a. What kind of pets?
- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

19a1. If other, please specify: _____

19a2. Are pet(s) allowed in patient's bedroom?
- ☐ Yes
- ☐ No

20. Other Environmental Triggers
- ☐ Yes
- ☐ No
- ☐ Resolved

20a. Other _____

21. Supplies provided

- ☐ Encasings- Mattress and Pillow
- ☐ HEPA Vacuum
- ☐ Integrated Pest Management Kit
- ☐ Other

21a. Specify Other _____

22. Referrals made

- ☐ Asthma Swim Program
- ☐ Breathe Easy - ISD
- ☐ Quitworks - smoking cessation service
- ☐ Other

22a. Specify Other _____

23. Recommendations

- ☐ Conduct Allergy Test
- ☐ Green cleaning
- ☐ Integrated pest management education
- ☐ Reduce clutter
- ☐ Remove pet from bedroom/home
- ☐ Smoke free home pledge
- ☐ Tobacco counseling
- ☐ Vacuum/dust/wash bedding weekly
- ☐ Work order/contact landlord re: violations
- ☐ Other

23a. Specify other _____

24. Progress Report Comments _____

Progress Report Home Visit 3

PROGRESS REPORT

Home Visitor: [home_visitor1]
Inspection Date: [inspection_date2]
Program ID: [program_id]

Asthma Control

1. ACT Score: [act_totalscore1]
(20-25 Well Controlled
16-19 Not Well-Controlled
0-15 Poorly Controlled)

2. Limitations in Activity
☐ Yes
☐ No

3. Recent ER visit since last home visit ?
☐ Yes
☐ No

3a. If yes, then how many? _____

4. Recent admission since last home visit?
☐ Yes
☐ No

4a. If yes, how many? _____

5. Asthma Action Plan Present
☐ Yes
☐ No

6. Medications all present
☐ Yes
☐ No

7. Is client adhering to their medication(s)?
☐ Yes
☐ No

8. Understand quick relief v. controller
☐ Yes
☐ No

9. Spacer present
☐ Yes
☐ No

10. Med Interventions
☐ Barriers to adherence (See comments)
☐ Call for refills
☐ Clarified current meds with clinic
☐ Contacted clinic for updated AAP
☐ Device demonstration repeat demo
☐ Go back to PCP for maintenance
☐ Review role/proper meds dosing
☐ Other

10a. Specify other _____

10a1. Please specify: _____

Environmental Triggers: Initial/Ongoing Issues

****Check whether it's an issue****

11. Cockroaches
- ☐ Yes
- ☐ No
- ☐ Resolved

11a. Status of cockroach issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

12. Rodents
- ☐ Yes
- ☐ No
- ☐ Resolved

12a. Status of rodents issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

13. Mold
- ☐ Yes
- ☐ No
- ☐ Resolved

13a. Status of mold issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

14. Dust/clutter/stuffed animals
- ☐ Yes
- ☐ No
- ☐ Resolved

14a. Resolved? [Dust/clutter/stuffed animals]
- ☐ Severe
- ☐ Moderate
- ☐ Mild

15. Unsanitary conditions
- ☐ Yes
- ☐ No
- ☐ Resolved

15a. Status of unsanitary conditions is
- ☐ Severe
- ☐ Moderate
- ☐ Mild

16. Carpeting
- ☐ Yes
- ☐ No
- ☐ Resolved

17. Environmental smoke
- ☐ Yes
- ☐ No
- ☐ Resolved

17a. If yes, please specify (check all that apply):
- ☐ Hookah
- ☐ Marijuana
- ☐ Tobacco
- ☐ Other
- ☐ Not sure

18. Strong cleaners VOCs
- ☐ Yes
- ☐ No
- ☐ Resolved

18a. Status of strong cleaners VOCs:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

19. Pets

- ☐ Yes
- ☐ No
- ☐ Resolved

19a. What kind of pets?

- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

19a1. If other, please specify: _____

20. Other Environmental Triggers

- ☐ Yes
- ☐ No
- ☐ Resolved

20a. Other _____

21. Supplies provided

- ☐ Encasings- Mattress and Pillow
- ☐ HEPA Vacuum
- ☐ Integrated Pest Management Kit
- ☐ Other

21a. Specify Other _____

22. Referrals made

- ☐ Asthma Swim Program
- ☐ Breathe Easy - ISD
- ☐ Quitworks - smoking cessation service
- ☐ Other

22a. Specify Other _____

23. Recommendations

- ☐ Conduct Allergy Test
- ☐ Green cleaning
- ☐ Integrated pest management education
- ☐ Reduce clutter
- ☐ Remove pet from bedroom/home
- ☐ Smoke free home pledge
- ☐ Tobacco counseling
- ☐ Vacuum/dust/wash bedding weekly
- ☐ Work order/contact landlord re: violations
- ☐ Other

23a. Specify other _____

24. Progress Report Comments _____

Secondary Home Progress Report Home Visit 3

Secondary Household
Progress Report

Environmental Triggers: Initial/Ongoing Issues

****Check whether it's an issue****

1. Is this the child's secondary household?
- ☐ Yes
- ☐ No

Please continue answering the following questions.

2. Limitations in Activity
- ☐ Yes
- ☐ No

3. Recent ER visit since last home visit ?
- ☐ Yes
- ☐ No

3a. If yes, then how many? _____

4. Recent admission since last home visit?
- ☐ Yes
- ☐ No

4a. If yes, how many? _____

5. Asthma Action Plan Present
- ☐ Yes
- ☐ No

6. Medications all present
- ☐ Yes
- ☐ No

7. Is client adhering to their medication(s)?
- ☐ Yes
- ☐ No

8. Understand quick relief v. controller
- ☐ Yes
- ☐ No

9. Spacer present
- ☐ Yes
- ☐ No

10. Med Interventions
- ☐ Barriers to adherence (See comments)
- ☐ Call for refills
- ☐ Clarified current meds with clinic
- ☐ Contacted clinic for updated AAP
- ☐ Device demonstration repeat demo
- ☐ Go back to PCP for maintenance
- ☐ Review role/proper meds dosing
- ☐ Other

10a. Specify other _____

10a1. Please specify: _____

11. Cockroaches
- ☐ Yes
- ☐ No
- ☐ Resolved

11a. Status of cockroach issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

12. Rodents
- ☐ Yes
- ☐ No
- ☐ Resolved

12a. Status of rodents issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

13. Mold
- ☐ Yes
- ☐ No
- ☐ Resolved

13a. Status of mold issue is:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

14. Dust/clutter/stuffed animals
- ☐ Yes
- ☐ No
- ☐ Resolved

14a. Status of dust/clutter/stuffed animals:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

15. Unsanitary conditions
- ☐ Yes
- ☐ No
- ☐ Resolved

15a. Status of unsanitary conditions is
- ☐ Severe
- ☐ Moderate
- ☐ Mild

16. Carpeting
- ☐ Yes
- ☐ No
- ☐ Resolved

17. Environmental smoke
- ☐ Yes
- ☐ No
- ☐ Resolved

17a. If yes, please specify (check all that apply):
- ☐ Hookah
- ☐ Marijuana
- ☐ Tobacco
- ☐ Other
- ☐ Not sure

18. Strong cleaners VOCs
- ☐ Yes
- ☐ No
- ☐ Resolved

18a. Status of strong cleaners VOCs:
- ☐ Severe
- ☐ Moderate
- ☐ Mild

19. Pets
- ☐ Yes
- ☐ No
- ☐ Resolved

19a. What kind of pets?
- ☐ Bird
- ☐ Cat
- ☐ Dog
- ☐ Rodent
- ☐ Other

19a1. If other, please specify: _____

20. Other Environmental Triggers

- ☐ Yes
- ☐ No
- ☐ Resolved

20a. Other _____

21. Supplies provided

- ☐ Encasings- Mattress and Pillow
- ☐ HEPA Vacuum
- ☐ Integrated Pest Management Kit
- ☐ Other

21a. Specify Other _____

22. Referrals made

- ☐ Asthma Swim Program
- ☐ Breathe Easy - ISD
- ☐ Quitworks - smoking cessation service
- ☐ Other

22a. Specify Other _____

23. Recommendations

- ☐ Conduct Allergy Test
- ☐ Green cleaning
- ☐ Integrated pest management education
- ☐ Reduce clutter
- ☐ Remove pet from bedroom/home
- ☐ Smoke free home pledge
- ☐ Tobacco counseling
- ☐ Vacuum/dust/wash bedding weekly
- ☐ Work order/contact landlord re: violations
- ☐ Other

23a. Specify other _____

24. Progress Report Comments _____

Six Month Follow Up

SIX MONTH FOLLOW UP

Home Visitor: [inspector2_6mo]
Inspection Date: [inspection_date2_6mo]
Program ID: [program_id]

1. Client discontinued program due to:
- ☐ Declines further contact
- ☐ Lost to follow-up
- ☐ Moved out of area
- ☐ Other

1a. If other, indicate reason client is inactive _____

2. Home Visitor _____

3. Inspection Date _____

4. In the past 4 weeks, how much of the time did asthma keep you/your child from getting as much done at work, school or home? (Choose 1)
- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

5. In the past 4 weeks, how often did your child experience shortness of breath?
- ☐ More than once per day
- ☐ Once per day
- ☐ 3 to 6 times per week
- ☐ Once or twice per week
- ☐ Not at all

6. In the past 4 weeks, how often did your/your child's asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning? (Choose 1)
- ☐ 4 or more nights per week
- ☐ 2 or 3 nights per week
- ☐ Once per week
- ☐ Once or twice
- ☐ Not at all

7. In the past 4 weeks, how often have you/your child used a rescue inhaler or nebulizer medication (such as albuterol)? (Choose 1)
- ☐ 3 or more times per day
- ☐ 1 to 2 times per day
- ☐ 2 or 3 times per week
- ☐ Once per week or less
- ☐ Not at all

8. How would you rate your/your child's asthma control? (Choose 1)
- ☐ Not controlled at all
- ☐ Poorly controlled
- ☐ Somewhat controlled
- ☐ Well controlled
- ☐ Completely controlled

9. Total ACT Score (Will populate itself when you save this form.) _____

10. In the past 6 months, how many times have you/your child been admitted to a hospital overnight because of asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 or more

11. In the past 6 months, how many times have you/your child been seen in the emergency room or urgent care center because of cough, wheezing, or shortness of breath from asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 or more

12. Besides those emergency room/urgent care visits, how many times have you/your child been seen in the doctor's office or clinic for asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 or more

13. In the past 6 months, have you/your child been prescribed a course of prednisone (3-5 days, liquid) for an asthma episode?

- ☐ Yes
- ☐ No

13a. How many times?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 or more

Asthma Medication

14. Do you have a written plan from your provider for managing your asthma (Asthma Action/Management Plan)?

- ☐ Yes
- ☐ No

15. When was the last time you/your child took any quick-relief medications to help relieve coughing, wheezing, shortness of breath, or tightness in the chest?

- ☐ N/A
- ☐ This morning
- ☐ Last night
- ☐ Yesterday
- ☐ 2 days ago
- ☐ 3-4 days ago
- ☐ A week ago
- ☐ Over a week ago

16. Are you/your child currently taking long-term controller medications for asthma?
- ☐ Yes
- ☐ No

16a. When was the last time you took your controller medication?
- ☐ N/A
- ☐ This morning
- ☐ Last night
- ☐ Yesterday
- ☐ 2 days ago
- ☐ 3-4 days ago
- ☐ A week ago
- ☐ Over a week ago

Environmental Issues

17. Do you or your child(ren) currently have a problem with dust?
- ☐ Yes
- ☐ No

17a. If yes, what is the status of the problem?
- ☐ Same
- ☐ Improved
- ☐ Worsened

18. Do you or your child(ren) currently have a problem with pests?
- ☐ Yes
- ☐ No

18a. If yes, what is the status of the problem?
- ☐ Same
- ☐ Improved
- ☐ Worsened

19. Do you or your child(ren) currently have a problem with mold?
- ☐ Yes
- ☐ No

19a. If yes, what is the status of the problem?
- ☐ Same
- ☐ Improved
- ☐ Worsened

20. Do you or your child(ren) currently have a problem with exposure to chemicals/fragrances?
- ☐ Yes
- ☐ No

20a. If yes, what is the status of the exposure?
- ☐ Same
- ☐ Some Exposure
- ☐ Moderate Exposure
- ☐ Heavy Exposure

21. Do you or your child(ren) currently have a problem with exposure to smoke?
- ☐ Yes
- ☐ No

21a. If yes, what is the status of the exposure?
- ☐ Same
- ☐ Some Exposure
- ☐ Moderate Exposure
- ☐ Heavy Exposure

22. Do you or your child(ren) currently have a problem with exposure to pets?
- ☐ Yes
- ☐ No

22a. If yes, what is the status of the exposure?
- ☐ Same
- ☐ Some Exposure
- ☐ Moderate Exposure
- ☐ Heavy Exposure

23. Six Month Follow Up Comments _____