Encounter Form Asthma HOME VISIT PROGRAM

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CHW: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time Started: \_\_\_: \_\_\_\_ AM/PM Time Finished: \_\_\_: \_\_\_\_ AM/PM Total Visit Time: \_\_\_\_\_(Minutes) Visit #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ASTHMA CONTROL TEST (ACT) Ages 12 & Up/ CHILD ASTHMA CONTROL TEST (CACT) Ages 4-11** | | | | |
| Was the ACT completed? | Yes | No | Adult Score: \_\_\_\_\_\_\_\_  Child Score: \_\_\_\_\_\_\_\_ | 20 or higher= Well controlled  16-19 = Not well controlled  15 or lower = Poorly controlled  20 or higher: Well controlled  13-19: Not well controlled  12 or lower: Poorly controlled |

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| **COORDINATION OF CARE WITH HEALTHCARE SYSTEM/PROVIDER** | | | | |
| **ACTIVITY SINCE LAST CHW VISIT** | **Planned Preventive Provider visits** | **Acute Asthma Provider Visits** | **Asthma Hospitalizations** | **Asthma ER/Urgent Care visits** |
| How many asthma-related medical visits? (Number) |  |  |  |  |
| Did they receive an oral steroid burst?  If yes, what date? (Date) |  |  |  |  |
| When is the next Primary Care Visit Scheduled? (Date) |  |  |  |  |
| Were there other asthma-provider visits?  (Date) |  | Type of visit: | | |

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| **ASTHMA MEDICATIONS REVIEW Caution: If on Seravent control must be on an ICS (ex: Flovent, Qvar, Pulmicort)** | | | | | | |
| **Medications Review** | **Yes** | **No** | **Current Meds** | **Yes** | **No** | **Name** |
| Were asthma medications discussed? |  |  | On Inhaled Control Medicine |  |  |  |
| Was DPI/MDI Technique correct? |  |  | On Inhaled Rescue Medicine |  |  |  |
| Was spacer used? |  |  | Other Asthma Medicines |  |  |  |
| Was adherent to meds? |  |  | Other Medicines |  |  |  |

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| **ASTHMA ACTION PLAN** | | | | | |
|  | **Yes** | **No** |  | **Yes** | **No** |
| Was a blank Action Plan given to client? |  |  | Was the Action Plan reviewed by CHW? |  |  |
| Has the client completed the action plan with Provider? |  |  | Was the Action Plan used when needed? |  |  |
| **Comments:** | | | | | |

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| **Protocols Addressed (Topics 1-4 Required)** | | | | | |
| **Educational Protocols** | | | **Environmental Protocols** | | |
| **Topic** | **Covered During Visit?**  **Yes No** | **Priority (Hight/Medium/Low)** | **Topic** | **Covered During Visit?**  **Yes No** | **Priority** (Hight/Medium/Low) |
| 1. **Asthma Basics** |  | H M L | 19. Air Pollution |  | H M L |
| 1. **Using an Asthma Action Plan** |  | H M L | 20. Allergies/Pollen |  | H M L |
| 1. **Warning Signs of Asthma** |  | H M L | 21. Assessing Household Products |  | H M L |
| 1. **Medication Adherence** |  | H M L | 22. Cleaning Checklist |  | H M L |
| 1. Colds and Asthma Care |  | H M L | 23.Clutter |  | H M L |
| 1. Communicating with Provider |  | H M L | 24.Cold Homes |  | H M L |
| 1. Depression |  | H M L | 25. Dust Control |  | H M L |
| 1. Getting Help During an Attack |  | H M L | 26. Dust Mites |  | H M L |
| 1. Influenza and Flu Shots |  | H M L | 27. Unsafe Housing |  | H M L |
| 1. Peak Flow Monitoring |  | H M L | 28. Environmental Tobacco Smoke |  | H M L |
| 1. Seeking Emergency Care |  | H M L | 29. Mold and Moisture |  | H M L |
| 1. Using a Dust Mask |  | H M L | 30. Asthma Triggers: Pets |  | H M L |
| 1. Using an MDI and Spacer/DPI |  | H M L | 31. Cockroaches |  | H M L |
| 1. Calling 911 |  | H M L | 32. Rodents |  | H M L |
| 1. What to do During an Attack |  | H M L | 33. Wood Smoke |  | H M L |
| 1. Obesity |  | H M L |  | | |
| 1. Spirometry |  | H M L |  | | |
| 1. Weight Loss |  | H M L |  | | |

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| **Supplies Given (Check all given)** | | | | | |
| * Medicine Box | * Storage Container 1.1 | * HEPA Air Purifier | * HEPA Vacuum |  | |
| * Safer Cleaning Kit | * Storage Container 1.5 | * Spacer | * Vacuum Bags (3 - 6) | |  |
| * Bedding Covers (CIRCLE ALL GIVEN) PILLOW – KING PILLOW – CRIB – TWIN – FULL – QUEEN – KING – CA KING | | | | | |

Date: \_\_\_\_\_\_\_\_\_\_\_\_ Client ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CHW: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Goal Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Barriers & Strategies to overcome:**

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**Next Steps:**

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Confidence (1-10): \_\_\_\_\_\_ Importance (1-10): \_\_\_\_\_\_

**Timeline (Short vs long term):**

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**Support & Resources:**

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**How much change will you do?**

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**When will you make this change?**

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**How often will you do this?**

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Accomplished by final visit? (Y/N): \_\_\_