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 controlled16-19 = Not well controlled15 or lower = Poorly controlled 20 or higher: Well controlled13-19: Not well controlled12 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
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| * Safer Cleaning Kit
 | * Storage Container 1.5
 | * Spacer
 | * Vacuum Bags (3 - 6)
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| * Bedding Covers (CIRCLE ALL GIVEN) PILLOW – KING PILLOW – CRIB – TWIN – FULL – QUEEN – KING – CA KING
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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):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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): \_\_\_