**V ISIT # 2**

**Form entered in database Visit #3 scheduled**

**The purpose of this interview is to collect information about you and your home environment as it relates to your asthma and safety. These questions are to guide the type of help you will receive. You do NOT have to answer any questions you do not want to. Your responses will not affect any of the services at the clinic or from your provider.**

**ASSESSOR**

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| **2. Questions for Children with Asthma, ages 4-11** |
| During the past **4 weeks, how many days** of work did you miss due to your child’s asthma? | **4+ 3 2 1 0*****(Circle One)*** |
| In the **last year, how many times** has your been hospitalized due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |
| In the **last year, how many times** has your child visited the Emergency Room due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |
| In the **last year, how many times** has your child visited Urgent Care or had a same day visit with their provider due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |

1. **Explain basic facts about Asthma:**
	1. The role of inflammation in a person with asthma compared to a person without asthma.
	2. What happens to a person’s airways during an asthma attack?
2. **Have each person with asthma fill out the “ACT” or “TRACK” appropriate for their age.**
3. **Explain what “well controlled” means.** Asthma patients are considered to have “well controlled asthma” when:
4. Daytime symptoms are fewer than two days per week ***AND***
5. Waking up at night from asthma symptoms occurs less than two times a month ***AND***
6. There are no limitations of activities

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| **1. Questions for Children with Asthma, ages 1-3** |
| During the past **4 weeks, how many days of school/daycare** did your child miss due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |
| During the past **4 weeks, how many work days** did you miss due to your child's asthma? | **4+ 3 2 1 0*****(Circle One)*** |
| In the **last year, how many times** has your child been hospitalized due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |
| In the **last** year, how many times has your child visited the Emergency Room due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |
| In the **last year, how many times** has your child visited Urgent Care or had a same day visit with their provider due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |

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| **3. Questions for Adults with Asthma, ages 12 & up** |
| During the past **4 weeks, how many days** of school or work did you miss due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |
| In the **last year, how many times** have you been hospitalized due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |
| In the **last year, how many times** have you visited the Emergency Room due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |
| In the **last year, how many times** have you visited Urgent Care or had a same day visit with your provider due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |

|  |  |
| --- | --- |
| Assessor Name:  | Visit date: |
| Client Name:  | Environmental Findings:CO2 \_\_\_\_\_\_\_\_\_ Temp \_\_\_\_\_\_\_\_ RH \_\_\_\_\_\_\_\_\_\_ |



**Page | 1**

Three Visit Model Tool Kit: Appendix 3

Home Visit 2 Form

DOH 345-341 August 2014

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 711).

**ASSESSOR: Review with client how to correctly use their inhaled medication and have them demonstrate their techniques.**

**3. Does the (person/people with asthma) demonstrate how to correctly use their inhaled medication?**

 Yes,\_\_\_\_ No,\_\_\_\_ Does not have medication,\_\_\_

**7. Since the last visit, has the (person/people with asthma) had to go to the emergency room or been hospitalized because of complications due to symptoms?**

 Yes, \_\_\_\_\_ No,\_\_\_\_\_\_

List anyone with asthma who ***has*** *been hospitalized due to symptoms*:

**4. On average, per week, how often do you use your**

**control medication as prescribed?**

 As Prescribed- All doses are taken per week

 5- 6 days per week

 3-4 days per week

 1-2 days per week

 Not at all

 Have not been prescribed control medication

**Why are they not taking medicines as prescribed?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Since visit #1, has a health care provider developed an ASTHMA ACTION PLAN and reviewed it with the person/people with asthma?**

 Yes, \_\_\_\_No, \_\_\_ Already has one

**ASSESSOR : If no, provide another Action Plan and encourage client to discuss it with a health care provider.**

**6. Has the person/people’s medication dosage or type changed since the last visit?**

 No, how many:

Who has ***not*** changed his or her asthma medication:

 Yes, how many:

Who ***has*** changed his or her asthma medication, the type of change, and the reason:

 N/A

Who does not use asthma medications:

**8. What are your allergies or asthma triggers (things that cause your asthma to act up) *(Check all that apply and list who has the sensitivity to the allergen)***

 Tobacco Smoke

 Pets/pet dander

 Household chemicals/cleaners

 Cockroaches/ rodents

 Poor ventilation/stale air

 Dust /dust mites

 Mold/mildew/moisture

 Change in weather

 Exercise

 Food/cooking

 Illness/virus/infection

 Fragrances/perfume

 Medicines

 Pollen/plants

 Wood/other smoke

 Aerosol cans/sprays

 Other:

 Other:

 Other:

 Other:

**TOBACCO SMOKE (SECOND HAND, THIRD HAND SMOKE)**

**9. Does the (person/people with asthma) smoke tobacco?** N/A No Yes, how often:

If yes, has this person/people tried to quit smoking in the past year? N/A No Yes, how many times:

**10. Does anyone else in the household smoke?** N/A No Yes, how often:

|  |  |  |
| --- | --- | --- |
| If yes, do you/they want to quit using tobacco within the next 20-30 days? | No | Yes |

**11. What is the rule about smoking in your home?**

 No one is allowed to smoke anywhere in my home, ever.

 Smoking is allowed. How often/circumstances?

**12. What is the rule about smoking in your car?**

 No one is allowed to smoke in my car ever.

 Smoking is allowed. How often/circumstances?

 N/A (no vehicle)

**ASSESSOR: If anyone is interested in quitting,**

1. **ASK** about tobacco use, and if ready to quit within 20-30 days

2.  **ADVISE** to quit

3.  **REFER** to appropriate service provider (1-800-QUIT-NOW or QUITLINE.COM)

**Talking Points**

- Every time you quit is a success/learned something new each time

- Takes 1-3 days to quit

- First 3 to 4 days are most difficult to overcome the nicotine addiction

|  |
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| **ASSESSOR : Discuss any suggestions that apply to the resident. Check one box for every suggestion.****If applicable, do Brief Tobacco Intervention to Assess willingness to quit.** |
| **Key Messages About Tobacco Smoke** | **Recommend** | **Compliant** | **Does Not Apply** |
| Use the quit-line (1-800-QUIT-NOW) or talk to a healthcare provider for support in quitting smoking. |  |  |  |
| Do not smoke/ do not allow other people to smoke in the home and/or vehicle. |  |  |  |
| When smoking outside, keep nearby doors and windows of the home closed. |  |  |  |
| Use a smoking jacket when you smoke outside. Remember to leave it outside, on the porch, or in the garage. |  |  |  |

**HOUSEHOLD PETS**

|  |  |
| --- | --- |
| **14. Are there any pet(s)?** | **If yes, what kind of pet(s)? Check all that apply** |
|  No Yes |  Dog(s) | Cat(s) | Bird(s) |  |
|  | Reptile(s) | Fish | Rodent(s) *(hamsters, mice, rats, guinea pigs)* |  Other  |
|  | **Are pets allowed in the house?** |  |
|  |  No Yes |  |  |  |
|  | **Are pets allowed in the bedrooms and/or on the furniture?** |
|  |  No Yes N/A |

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| **ASSESSOR : Discuss any suggestions that apply to the resident. Check one box for every suggestion.** |
| **Key Messages About Household Pets** | **Recommend** | **Compliant** | **Does Not** **Apply** |
| If possible, remove any furry pets from the home or keep them outside. |  |  |  |
| Keep furry pets out of bedrooms/sleeping areas and off the furniture.If not possible, cover the bedding and furniture with sheets or slip covers and wash regularly in hot water. |  |  |  |
| Use pet bedding or have designated pet areas.Clean the bedding in hot water, and the floor regularly to control excess fur, dander and fleas. |  |  |  |

**HOUSEHOLD CHEMICALS/CLEANERS**

**ASSESSOR : Ask homeowner to show what types of cleaners are used.**

|  |  |
| --- | --- |
| **15. How often are cleaners with strong odors used?***(glass cleaner, mildew remover, bleach, all-purpose cleaners )*  Frequently Rarely/Never None in House | **19. Are there members of the household who work with hazardous materials on the job?*( asbestos, batteries, lead, paint, pesticides)*** |
| **16. Where are hazardous household chemicals and/or cleaning products stored ?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  No Yes |
| **17. Do you use candles, incense or air fresheners?** No Yes | **20. If a member works with hazardous materials, before coming home they (check all that apply)** |
| **18. Does anyone in the home dry-clean his or her clothing?** No Yes, how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Change clothes Change shoes ShowerDon’t know/none of these choices |

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| **ASSESSOR : Discuss any suggestions that apply to the resident. Check one box for every suggestion.** |
| **Key Messages About Household Chemicals/Cleaners** | **Recommend** | **Compliant** | **Does Not Apply** |
| Use non-toxic/green cleaning products whenever possible. Follow instructions on product packages. |  |  |  |
| Store hazardous products away from children, pets, heat, or fire, and preferably out of the house and garage. |  |  |  |
| Air out dry-cleaned clothing before bringing indoors. |  |  |  |
| Wash and keep clothes that may have been exposed to industrial chemicalsor pesticides separate from other items. |  |  |  |

**PEST CONTROL**

**21. Has the homeowner seen any sign of ants/ spiders/ fleas, cockroaches, rodents, and/or other pests?**

 No Yes, cockroaches Yes, rodents Yes, other pests:

**22. Is the outside of the home treated****(sprayed with pesticide) for pests?**

 No Yes, how many times a year:

**23. Are there food crumbs or unsealed food visible (in the kitchen, pet food bowls etc.)?**

 No Yes, locations:

**24. Are there holes or gaps in walls, around plumbing, doorjambs, etc. that would allow pests to enter the home?**

 No Not sure Yes, locations:

|  |
| --- |
| **ASSESSOR : Discuss any suggestions that apply to the resident. Check one box for every suggestion.** |
| **Key Messages About Pest Control** | **Recommend** | **Compliant** | **Does Not****Apply** |
| Clean all surfaces where you have seen pests. |  |  |  |
| Use baits, boric acid and traps to kill pests. Try not to use sprays. If you must use, follow all of the instructions on the label. |  |  |  |
| Clean up spills and crumbs immediately. Store food in sealed containers. Clean dishes daily; don’t wait until the morning. |  |  |  |
| Keep garbage in sealed bags. Remove all newspapers, cardboard, and other pest-nesting materials. Clean up garbage or debris on the property |  |  |  |
| Seal all holes and gaps if possible. |  |  |  |

**VENTILATION**

**25. Does the heating and/or cooling system use filters?**

 Yes No Not Sure

**26. Does the heating system use a fuel burning substance (such as oil or gas)?**

 Yes No Not Sure

**27. Is there a gas-cooking stove?**

 Yes No

**28. Is there any kind of supplemental heating in your home?**

 No Fireplace Wood burning stove, is it EPA-certified? Yes No

 Unvented kerosene or gas space heater Electric space heater *(radiator style, hot oil, anything that plugs in to the wall)*

 Other:

**29. Are there air conditioning window units?**

 No Yes, all the time Yes, seasonal use

**30. Is there a stand-alone air purifier?**

 No HEPA Ionizing/Ozone Other:

**31. Are all of the windows able to be opened in every room?**

 Yes No, which rooms?

**32. Are there screens on every door and window?**

 Yes, some Yes, all No 

**33. Is the home near a busy street, intersection, bus station, dry cleaner, mills, school, etc?**

 No Not Sure Yes, details:

|  |
| --- |
| **ASSESSOR : Discuss any suggestions that apply to the resident. Check one box for every suggestion.** |
| **Key Messages About Ventilation** | **Recommend** | **Compliant** | **N/A** |
| Clean or replace filters quarterly. Use pleated paper style filter. |  |  |  |
| Have heating systems inspected annually, including baseboards, ductwork, chimneys, wood stove doors, wall heater plates. |  |  |  |
| Vacuum wall heaters behind their grate, baseboards, and/or the first 5-1inches of floor vents/duct work every couple of months to prevent particulates from blowing out of the system.  |  |  |  |
| Ensure that fuel burning appliances are vented to the outside. Never use a gas stove as a heating source. |  |  |  |
| Install carbon monoxide meters. |  |  |  |
| Use the vent option on air conditioner window units.  |  |  |  |
| Ionizing/ozone air purifiers produce ozone, which may be dangerous for those with respiratory issues. Use HEPA air cleaners if needed. |  |  |  |
| Keep indoor humidity at 30-50% and temperature at 68-72 degrees. Flush the house once a day for 10 minutes, do this year round. When cooking or showering, open windows and/or use fans.  |  |  |  |
| Keep windows and doors closed when there are high pollen counts, high levels of traffic, or poor outdoor air quality days.  |  |  |  |
| EPA certified wood stoves heat better and pollute less. |  |  |  |
|  Use efficient wood burning techniques. |  |  |  |

**DUST/MITES/TRACK IN/CLEANING**

|  |
| --- |
| **41. Is there a working vacuum in the house?** No  N/A Not sure Yes, what kind:  Regular bag Regular bag-less High efficiency/dust sensor HEPA  Other:  |
| **42. Are allergen covers used on mattresses and/or pillows?** No  Yes, on some  Yes, on all |

**34. How is tracked in dirt and debris handled?**

 Door mats  Remove shoes at the door

 Nothing  Other:

**35. What kind of flooring is in the home?**

|  |  |  |
| --- | --- | --- |
|  Hard surface |  Carpet |  Area rugs |

**36. How do you clean your area rugs?**

|  |  |  |
| --- | --- | --- |
|  No area rug |  Vacuum |  Shake or sweep |
|  Don’t clean |  Wash |  Other:  |

**37. How often is bedding changed and washed?**

|  |  |
| --- | --- |
|  once a week or more |  once every month |
|  once every two weeks |  longer than once a month |

**38. What temperature setting is normally used to wash bedding?**

 Hot  Warm  Cold

**39. If curtains/drapes present, how are they cleaned?**

|  |  |  |
| --- | --- | --- |
|  Shake them |  Wash in machine |  N/A |
|  Vacuum |  Not cleaned |  Other:  |

**40. If shades/blinds present, how are they cleaned?**

|  |  |  |
| --- | --- | --- |
|  Feather duster |  Water (hose/bathtub/spray bottle) |  Not cleaned |
|  Damp cloth or microfiber  |  N/A |  Other:  |

|  |
| --- |
| **ASSESSOR : Discuss any suggestions that apply to the resident. Check one box for every suggestion.** |
| **Key Messages About Dust/Mites/Track In/Cleaning** | **Recommend** | **Compliant** | **Does Not****Apply** |
| Vacuum and/or sweep at least weekly. Including under furniture and beds. |  |  |  |
| Use a high efficiency vacuum with a HEPA filter if possible.Sweep with a static cling or microfiber dust mop rather than a broom to trap dust and debris. Damp or wet mop, using non-toxic floor cleaner or just water. |  |  |  |
| Use a damp or microfiber/static cling cloth to dust.Start from the top of furniture/windows, and work your way down. |  |  |  |
| Empty canisters or replace bags outside and before they are full. |  |  |  |
| Remove sensitive persons from the room if possible while cleaning. If not possible, sensitive persons can wear a dust mask. |  |  |  |
| Cover pillows and mattresses with zippered allergen covers |  |  |  |
| Change and wash bedding in hot water weekly. |  |  |  |
| If possible, wash decorative pillows and stuffed toys in hot water every 3 months.If not washable, place in dryer for 30 minutes or in freezer for 24 hours. Limit the number of decorative pillows and stuffed toys in the bedrooms. |  |  |  |
| Use door mats inside and outside of all doors. Create a shoe off policy if possible. Clean mats at least once every 3 months. |  |  |  |

**MOISTURE CONTROL/MOLD**

**43. Has there been any water damage, moisture, or leaks in the home (or signs of previous problem)?**

 No  Yes, where: Not sure

**44. Is there any method to measure humidity in the home?**

 No  Yes, what: Not sure

**45. Are there any signs of mold or mildew (walls, windows, bathtub, closets, etc.)?**

 No

 Yes, but only in limited spots. Where:

 Yes, in large areas or in many places within the home. Where:

**46. Do windows other than in the bathroom and kitchen fog up?**

 No  Yes, where: Not sure

**47. Is there a working exhaust fan over the stove that is vented to the outside?**

 No  Yes, where: Not sure

**48. Does the bathroom window or mirror stay fogged up for more than 15 minutes after the shower is used?**

 No, in how many bathrooms:

 Yes, in how many bathrooms:

**49. Is there a working exhaust fan in the bathroom(s) that is vented to the outside?**

 No, in how many bathrooms:

Yes, in how many bathrooms:

**50. Are there any humidifiers in the home or (refrigerator/air conditioner drip pans, excessive houseplants, an aquarium, and/or under sinks)?**

 No  Yes Not sure

**51. If a dishwasher is present, is it properly vented to the outside (steam will come out of the machine if not vented)?**

 No  Yes Not sure

**52. If a clothes dryer present, is it properly vented to the outside?**

 No  Yes Not sure

**53. Are the roof and gutters in good condition?**

 No  Yes, some  Yes, all Not sure

**54. Is the basement or crawl space well ventilated?**

 No  Yes Not sure N/A (apartment building)

**55. Do the basement / crawl space have a moisture barrier on the soil surface?**

 No  Yes Not sure N/A (apartment building)

**Assessor: List areas of elevated moisture (measured with a flat surface moisture meter):**

|  |
| --- |
| **ASSESSOR : Discuss any suggestions that apply to the resident. Check one box for every suggestion.** |
| **Key Messages About Moisture Control/Mold** | **Recommend** | **Compliant** | **Does Not****Apply** |
| Fix water leaks as soon as possible.Replace mold damaged materials as needed. Refer to Mold FAQs. |  |  |  |
| Monitor humidity levels in the home by purchasing an inexpensive hygrometer.Levels should remain between 30% and 50% humidity. |  |  |  |
| Clean mold as needed. Refer to Mold FAQs. |  |  |  |
| Keep the inside of the house dry with ventilation. Open doors and windows to dry floors and walls.Crack open windows to dry windowsills, pull furniture away from walls to let air flow through, and open closets often. |  |  |  |
| Properly vent all moisture producing appliances to the outside.Clean dryer vents and refrigerator coils every 3 months. |  |  |  |
| Always open windows or use exhaust fans when cooking and after bathing for at least 30-60 minutes. |  |  |  |
| Keep up with the outside maintenance as needed. |  |  |  |

**MISCELLANEOUS**

**56. Does the home meet criteria for possibly containing lead (high levels of lead in soil, lead based paint used before**

**1978, etc.)?**

 No  Yes Not sure

**57. Is there an attached garage/carport in the home?**

 No  Yes

**58. Are the common walls/doors between the house and garage/carport sealed and without holes?**

 No  Yes Not sure N/A

**59. In cold weather, is the car warmed up in the garage or carport?**

 No  Yes Not sure N/A

**60. Are there any hazardous chemicals or toxic materials stored in the garage/carport?**

 No  Yes Not sure N/A

|  |
| --- |
| **ASSESSOR : Discuss any suggestions that apply to the resident. Check one box for every suggestion.** |
| **Key Messages** | **Recommend** | **Compliant** | **Does Not****Apply** |
| If you suspect you home has lead hazards: consult EPA Lead Guide.Clean up paint chips immediately, wash hands often (especially children’s); keep children from chewing on painted surfaces.Temporarily or permanently reduce or remove lead hazards from the home. |  |  |  |
| Use caution when cleaning or painting over materials containing asbestos Seek professional assistance for remediation if needed. Do not attempt to remove or remodel without speaking to a professional first. |  |  |  |
| Avoid idling in the garage/carport. |  |  |  |
| Avoid storing toxic chemicals or hazardous materials in the garage/carport if possible. If you must, store them at the part of the garage/carport farthest away from the home, seal containers if possible, and ventilate the area. |  |  |  |

**ASSESSOR: If triggers were addressed on Visit #1, Review findings. Go through the residence with the homeowner(s) and review major triggers from the last visit. Advise where appropriate.**

**10. Were major triggers identified in the last visit remediated?**

 Yes, number of major triggers successfully remediated since visit #1: \_\_\_\_\_\_

NOTES:

Major triggers that are still being worked on:

**ASSESSOR: Length of Assessment**

 30 - 60 minutes  60 - 90 minutes 90 - 120 minutes 120 + minutes