**V IS IT # 3**

**Form entered in database Follow-up call made**

**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**

1. **Review with the resident the basic facts about asthma, and ask if they have any questions from**

**the last visit.**

1. **Have each person with asthma fill out the ACT or TRACK appropriate for their age.**

**C. Explain what “well controlled” means.**

Asthma patients are considered to have

“well controlled asthma” when:

1. Daytime symptoms are fewer than two days per week ***AND***

2. Waking up at night from asthma symptoms occurs less than two times a month ***AND***

3. There are no limitations of activities

**1. Questions for Children with Asthma, ages 1-3**

|  |  |
| --- | --- |
| During the past **4 weeks, how many days** of 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)*** |

**2. Questions for Children with Asthma, ages 4-11**

|  |  |
| --- | --- |
| 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)*** |
| 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** y**ear, 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 your provider due to asthma? | **4+ 3 2 1 0*****(Circle One)*** |

**3. Questions for Adults with Asthma, ages 12 & up**

|  |  |
| --- | --- |
| During the past **4 weeks, how many days** of 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 \_\_\_\_\_\_\_\_\_\_ |



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).

DOH 345-341 August 2014

Three Visit Model Tool Kit: Appendix 4

Home Visit 3 Form

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

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

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

**8. 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*:

**5. 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?**

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

**6. Since visit #2, 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.**

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

 No, how many:

List anyone with asthma who has ***not*** changed his or her

asthma medication:

**9. Do you or anyone else in the house smoke or chew tobacco?**

 Yes No

If yes, do you/they want to quit using tobacco within the next 20-30 days?

 Yes No

**ASSESSOR: If YES, provide Brief Tobacco**

**Intervention Skills (BTIS): 2 A’s and an R**

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

 Yes, how many:

List anyone with asthma who ***has*** changed his or her

asthma medication, the type of change, and the reason:

 N/A

List anyone with asthma who does not use asthma

medications:

**ASSESSOR: Review findings from Visit #2. 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 #2:

NOTES:

Major triggers that are still being worked on:

|  |
| --- |
| **ASSESSOR : Discuss any suggestions that apply to the resident. Check one box for every suggestion.** |
| **Task and Message for Asthma** | **Recommend** | **Compliant** | **Does Not****Apply** |
| Asthma will be better and worse at times. Track all symptoms in the journal provided. Write down where you were, what time of day, and what you were doing to establish triggers.**ASSESSOR: Explain Symptom Journal** |  |  |  |
| If you have a health care provider, make an appointment to be seen for asthma if you have not been recently.Adults with asthma should see their provider at least once a year. Children with asthma should see their provider at least every six months. |  |  |  |
| If you do not have a health care provider, attempt to make an appointment for asthma management at one of the clinics suggested.**ASSESSOR: Give brochures for Free Clinic or other local resources.** |  |  |  |
| Use the form provided to you to develop an Action Plan with a health care provider. Update it every year or when there are changes in your condition. |  |  |  |
| Use spacers and/or masks as directed when using inhaled medications. Use the information provided on how to use inhaled medications properly.**ASSESSOR: Give client a spacer and show them how to use it. Hand out written instructions.** |  |  |  |
| **ASSESSOR:** If the person with asthma smokes, and would like to quit within the next 30 days, administer the BTIS. |  |  |  |
| Use controller medications if prescribed by your provider. Asthma is not controlled if using rescue medication more than 2 times a week. Let your provider know if your asthma is not controlled. |  |  |  |
| Avoid triggers to control your asthma. Follow the suggestions provided in the 2nd visit. **ASSESSOR:** Let the person know that they can feel free to call the program again if they need further assistance. |  |  |  |
| The goal is to have well controlled asthma. If asthma is not well controlled, follow the advice given during this in-home assessment, or see provider.**ASSESSOR: Give client their copy of tasks/messages. Let them know someone will call them to follow-up in 4-6 weeks.** |  |  |  |

**ASSESSOR:**

**Length of Assessment**

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

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