HEALTHWAYS

ASTHMA - GUIDELINES FOR CARE CHECKLIST

Patient Name:	**Patient ID#:**			
Date of Birth:	**Patient Phone #:**			
Provider Name:	**Provider Phone #:**			
INTERVENTIONS	**DATE**	**DATE**	**DATE**	**DATE**
Depression Screen (PHQ-2 or PHQ-9)				
Weight (lbs or kg)				
Height				
BMI				
Review Action Plan, Symptoms and Peak Flow Diary				
Smoking Status: Cigarette Smoker (Y/N) Other tobacco products (Y/N) _____ If yes: Was cessation addressed? (Y/N) (5 "As": Ask, Advise, Assess, Assist, Arrange) Pharmacotherapy for cessation (Y/N) _____				
Frequency of Symptoms				
Activity Level				
Exacerbation Frequency ER visit/Hospitalization?				
Peak Flow Rate LPM (Personal Best:_____) Compare to Personal Best				
Peak Flow, Spacer or Holding Chamber - Demonstrate Technique				
Medication Review: Does patient have a 30-day supply of *reliever* meds?				
Medication Adherence				
Goals of Therapy: Met/Not Met				
Trigger Control Plan				
Medications:	**Y/N/NA**	**Y/N/NA**	**Y/N/NA**	**Y/N/NA**
Short Acting Beta Agonist				
Long Acting Beta Agonist				
Anticholinergic				
Inhaled Corticosteroid				
Leukotriene Antagonist				
Methylxanthine (e.g., Theophylline)				
Oral Corticosteroid				
Mast Cell Membrane Stabilizer (e.g., Cromolyn)				
Osteoporosis Treatment				
Antibiotic				
Smoking Cessation Aids				
ANNUAL or AS INDICATED	**Results**	**Results**	**Results**	**Results**
Spirometry: FEV1/FVC/% Predicted				
Serum Theophylline Level Steady-state maintained at 5-15 mcg/mL				

Allergy Testing (all persistent)				
Immunizations	**Date**	**Lot #**	**Lot #**	**Lot #**
Flu Vaccine (annual, unless intolerant or contraindicated)				
Pneumonia Vaccine (as indicated) http://www.cdc.gov/vaccines/schedules/hcp/adult.html				