Asthma Flow Sheet

Ages 5 to 11

Patient name: _____ **Identification number:** _____

Date of birth: _____ **Current date:** _____

Chart ID: _____

Vital signs and lung function tests

Height:		**Blood pressure:**	/	**Spirometry/FEV_1:** (☐ unable to perform)			%
Weight:		**Pulse:**		**Peak flow:** personal best		**Est. for height:**	
Temp.:		**Pulse oximetry:**	%	**Peak flow rate:**	#	**Peak flow rate:**	%
Resp. rate:		**Post treatment:**	%	**Post-tx peak flow rate:**	#	**Post-tx peak flow rate:**	%

Education

Self management strategies and return demonstration where appropriate.

☐ Medication
- Controller
- Rescue

☐ Exercise

☐ Medication administration
☐ Peak flow meter use (if applicable)
☐ Set and review treatment goals
☐ Avoiding triggers

Presenting issues

Is the patient having an exacerbation? ☐ Yes ☐ No

Has the patient had a recent trigger exposure? ☐ Yes ☐ No

Physical exam

Chest/respiratory

☐ Lungs clear to auscultation ☐ Prolonged expiration ☐ Nasal flaring

☐ Shallow breath sounds (describe): _____

☐ Wheeze (describe): _____

☐ Retractions (describe): _____

☐ Other sounds (describe): _____

Eye-ear-nose-throat _____

Skin _____

Treatment at visit

Xopenex/levalbuterol neb: ☐ 0.63mg ☐ 1.25mg/3ml

Albuterol neb: ☐ 2.5mg/3ml

☐ Other: _____ # of treatments _____

☐ Prelone given; dose: _____

_____

Referred to:

☐ Allergist ☐ Pulmonologist

Asthma action plan

☐ Reviewed with patient

☐ Provided and/or updated

☐ Copy for daycare or school

Current symptoms

☐ No symptoms

☐ Wheeze ☐ Cough

☐ Sputum ☐ Chest tight/dyspnea

☐ Shortness of breath (SOB)

☐ Other: _____

Recent daytime symptoms

☐ 0 days/week

☐ 1–2 days/week

☐ 3–6 days/week

☐ Every day

☐ Continual (multiple symptoms/day)

Recent nighttime symptoms

☐ 0x/month ☐ 1–2x/month

☐ 3–4x/month ☐ 5–11x/month (1–2x/week)

☐ Greater than or equal to 12x/month (greater than 3x/week)

B_2-agonist use

☐ None ☐ 1–2 days/week

☐ 3–6 days/week

☐ 7 days/week

☐ Greater than 2x every day

Avg. # puffs/day _____

Emergency room visits for asthma

(due to asthma, last month)

☐ 0 ☐ 1 ☐ 2

☐ 3 ☐ 4 ☐ Greater than 4

Hospitalizations in last year: _____

Missed school/work

(due to asthma, last two weeks)

☐ None ☐ 5–6 days

☐ 1–2 days ☐ 7–8 days

☐ 3–4 days ☐ 9–10 days

Home peak flow rates

Personal Best: _____ ☐ N/A

☐ Green zone _____ to _____

☐ Yellow zone _____ to _____

☐ Red zone _____ to _____

Comorbidities

☐ Allergies ☐ Eczema ☐ Hypertension

☐ GERD ☐ Depression ☐ None

☐ Anxiety ☐ Sinusitis ☐ Other

Triggers

☐ Mold ☐ Dust

☐ Cat ☐ Dog

☐ Cigarette smoker

☐ Cockroach

☐ Other: _____

Impact on activity

☐ No effect on any activity

☐ May affect physical activity

☐ Activity often affected

☐ Limited physical activity

Describe: _____

Medication compliance

Missed or stop taking medications? ☐ Yes ☐ No If Yes, why? _____

Any side effects?

☐ Nervousness ☐ Shakiness ☐ Sore throat

☐ Bad taste ☐ Cough ☐ Bruising

Any barriers getting the ordered medications? _____

Today's control rating

Symptoms (SOB, coughing, wheezing)	**Nighttime awakening**	**B_2-agonist use**	**Interference with normal activity**	**Lung function FEV_1 or peak flow FEV_1/FVC**	**Exacerbation requiring oral systemic corticosteroids**	**Control rating**
☐ Throughout the day	☐ Greater than or equal to 2x/week	☐ Several times per day	☐ Extremely limited	☐ Less than 60% predicted/ personal best, less than 75%	☐ Greater than or equal to 2/year	☐ Very poorly controlled
☐ Greater than 2 days/week	☐ Greater than or equal to 2x/month	☐ Greater than 2 days/week	☐ Some limitations	☐ Less than 60–80% predicted/ personal best, less than 75–80%		☐ Not well-controlled
☐ Less than or equal to 2 days/week	☐ Less than or equal to 1x/month	☐ Less than or equal to 2 days/week	☐ None	☐ Greater than 80% predicted/ personal best, greater than 80%	☐ 0–1/year	☐ Well-controlled

Follow-up

☐ 2 weeks ☐ 4 weeks ☐ 2 months ☐ 3 months ☐ 4 months ☐ 6 months

Medications prescribed

Key: GERD, gastroesophageal reflux disease; FEV_1 forced expiratory volume in one second; FVC, forced vital capacity

UnitedHealthcare®

UHC1824g_20120321 100-4225 6/12

HEDIS ASTHMA MGMT WKSHT 5–11

1

PERISCOPE®

JOB # UCS120067 **DATE** 6.11.12
CLIENT UnitedHealthcare Community & State

NAME HEDIS Collateral

TRIM 8.5" x 11"
BLEED .125"
FOLDED N/A
FILE CREATED AT: 100%

COLOR CMYK

C M Y K

	INITIALS	DATE
CD Bruce B		
AD/DS Nick C		
CW Linda L		
AM Sarah M/Jonathan C		
PM Mandi T		

STAGE: FINAL

Recommended action for treatment

See chart below for treatment steps.

- Maintain current step
- Regular follow-ups every one to six months
- Consider step-down if well-controlled for at least three months

- Step-up at least one step and reevaluate in two to six weeks
- For side effects, consider alternative treatment options

- Consider short course of oral systemic corticosteroids
- Step-up one to two steps and reevaluate in two weeks
- For side effects, consider alternative treatment options

Notes

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- The level of control is based on the most severe impairment or risk category. Assess impairment domain by patient's/caregiver's recall of previous two to four weeks and by spirometry/or peak flow measures. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient's asthma is better or worse since the last visit.
- At present, there is inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization or intensive care unit admission) indicate poorer disease control. For treatment purposes, patients who had less than two exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.
- Before step-up in therapy:
  - Review adherence to medications, inhaler technique, environmental control and co-morbid conditioning.
  - If alternative treatment option was used in a step, discontinue it and use preferred treatment for that step.

Stepwise approach for managing asthma in children ages 5 to 11

Intermittent asthma	Persistent asthma: daily medication Consult with asthma specialist if Step 4 care or higher is required. Consider consultation at Step 3.					
Step 1 **Preferred:** SABA pro re nata	**Step 2** **Preferred:** Low-dose ICS **Alternative:** Cromolyn, LTRA, nedocromil or theophylline	**Step 3** **Preferred:** EITHER Low-dose ICS + either LABA, LTRA or theophylline OR Medium-dose ICS	**Step 4** **Preferred:** Medium-dose ICS + LABA **Alternative:** Medium-dose ICS + either LTRA or theophylline	**Step 5** **Preferred:** High-dose ICS + LABA **Alternative:** High-dose ICS + either LTRA or theophylline	**Step 6** **Preferred:** High-dose ICS + LABA + oral systemic corticosteroid **Alternative:** High-dose ICS + either LTRA or theophylline + oral systemic corticosteroid	**Step-up if needed** First, check adherence, inhaler technique and co-morbid conditions, environmental control **Assess control** **Step-down if possible** If asthma is well controlled for at least three months

Key: Alphabetical order is use when more than one treatment option is listed within either preferred or alternative therapy. ICS, inhaled corticosteroid; LABA, inhaled long-acting $beta_2$-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting $beta_2$-agonist

Each step: Patient education, environmental control and management of co-morbidities

Steps 2 to 4: Consider subcutaneous allergen immunotherapy for patients who have allergic asthma (see notes).

Quick-relief medication for all patients

- SABA as needed for symptoms. Intensity of treatment depends on severity of symptoms: up to three treatments at 20-minute intervals as needed. Short course of oral systemic corticosteroids may be needed.
- Caution: Increasing use of SABA or use less than two days a week for symptom relief (not prevention of exercise-induced bronchospasm) generally indicates inadequate control and the need to step-up treatment.

Notes

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- If alternative treatment is used and response is inadequate, discontinue it and use the preferred treatment before stepping up.
- Theophylline is a less desirable alternative due to the need to monitor serum concentration levels.

- Step 1 and Step 2 medications are based on Evidence A. Step 3 ICS + adjunctive therapy and ICS are based on Evidence B for efficacy of each treatment and extrapolation from comparator trials in older children and adults — comparator trials are not available for this age group; Steps 4 to 6 are based on expert opinion and extrapolation from studies in older children and adults.
- Immunotherapy for Steps 2 to 4 is based on Evidence B for dust mites, animal danders, and pollens; evidence is weak or lacking for molds and cockroaches. Evidence is strongest for immunotherapy with single allergens. The role of allergy in asthma is greater in children than in adults. Clinicians who administer immunotherapy should be prepared and equipped to identify and treat anaphylaxis that may occur.

Key: EIB, exercise-induced bronchospasm; GERD, gastroesophageal reflux disease. FEV_1, forced expiratory volume in one second; FVC, forced vital capacity
Source: www.nhlbi.nih.gov/guidelines/asthma/

UHC1824g_20120321