ASTHMA GUIDELINES FOR CARE FLOW SHEET

Patient Name:		Physician Name:		
Date of Birth:		Medical Record #:		
INTERVENTIONS	DATE	DATE	DATE	DATE
Review Daily Action Plan, Symptoms and Peak Flow Diary				
Smoking Status (Y/N) If yes: Advised to quit?; 5 "As": Ask, Advise, Assess, Assist, Arrange				
Frequency of Symptoms				
Activity Level				
Exacerbation Frequency ER/Urgent Care visit? Hospitalization?				
Peak Flow Rate LPM Compare to Personal Best				
Peak Flow, Spacer or Holding Chamber Technique				
Medication Review/Adherence Do they have 30-day supply of reliever meds?				
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/Nedocromil				
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)				
PREVENTIVE:	Date	Lot #		
Flu Vaccine (annual)				
Pneumococcal Vaccine				

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