

Virtual visit 1

Case ID	488
Initial Virtual Home Visit	
Date and time of initial home visit	<input type="text"/> M-D-Y H:M
* must provide value	
Name of Interviewer	<input type="text"/>
* must provide value	
Other Staff assigned	<input type="text"/>
Status of Home Visit	<input type="radio"/> Successful <input type="radio"/> Unsuccessful
* must provide value	
Status	<input type="radio"/> Visit Complete <input type="radio"/> No Visit
* must provide value	
Client Contact Information	
Do I have your consent to carry out this home visit, to ask you questions about your home and your child's asthma for the purpose of providing educational materials that may reduce the environmental triggers in your home? Yes or NO	<input type="radio"/> Yes <input type="radio"/> No
First Name	<input type="text"/>
Last Name	<input type="text"/>
Primary number	<input type="text"/>
Alternative Number	<input type="text"/>
Address	<input type="text"/>
Patient Name	<input type="text"/>
* must provide value	this is who suffers from asthma
Patient Age	<input type="text"/>
* must provide value	
Household Information	
Female Head of Household	<input type="text"/>
Total number of persons living in household	<input type="text"/>
What is the approximate household annual income?	<input type="text"/>
Do you like the neighborhood?	<input type="radio"/> Yes <input type="radio"/> No
Do you think this is someplace you would like to stay for a while?	<input type="radio"/> Yes <input type="radio"/> No
Please explain why or why not you would want to stay in in this neighborhood.	<input type="text"/>
How many times in the last 12 months have you changed residences?	<input type="radio"/> none <input type="radio"/> 1 time <input type="radio"/> 2 times <input type="radio"/> 3 times <input type="radio"/> 4 times <input type="radio"/> 5 or more times

Do you rent or own?

- ☐ Rent
☐ Own

How much is your rent or mortgage per month?

Are you currently late on your rent or mortgage payments?

- ☐ Yes
☐ No

Do you have homeowner's or renter's insurance

- ☐ Yes
☐ No

Do you live in public housing?

- ☐ Yes
☐ No

Asthma Questions

Name of patient with asthma

Gender of patient

- ☐ male
☐ female

date of birth

 M-D-Y

age of patient at time of visit

Does the person with asthma also have a disability?

Is this person of Hispanic, Latino or Spanish origin?

What is this person's race?

- ☐ Black
☐ White
☐ American Indian or Alaskan Native
☐ Asian
☐ Pacific Islander
☐ Other

What does 'successful asthma management' mean for you?
For example, 'successful asthma management' could mean you can go dancing again, or do more gardening (or other hobby), or simply feel less worn out during the course of your daily activities.

How are your/your child's asthma symptoms right now?

- ☐ out of control
☐ poorly controlled
☐ somewhat controlled
☐ well controlled
☐ I don't know
- ☐ animals/pets
☐ cleaning supplies (bleach, detergents, etc)
☐ dust mites
☐ exercise/physical activity
☐ food allergies
☐ illnesses (cold, respiratory infections, etc)
☐ mold
☐ strong smells (perfumes, fragrances, etc)
☐ pollen
☐ pollution
☐ pests/rodents (mice, rats, cockroaches, etc)
☐ tobacco smoke
☐ weather
☐ intense emotions/stress
☐ other
☐ don't know/uncertain

What triggers your/your child's asthma? select all that apply

Did you know there are "asthma-friendly" ways to clean surfaces in a way that kills the COVID virus?

- ☐ Yes
☐ No

Below are some "asthma-friendly" ways to kill the COVID virus.

- ☐ Use low-odor disinfectants like Ethyl Alcohol (rubbing alcohol) or up to 3% Hydrogen Peroxide

[Use the Indoor Air Pollution and EPA checklist front page for triggers.](#)

Which, if any of these, can work for your household?

and not products meant for industrial or hospital use.

- ☐ Have the asthmatic person stay in another room when cleaners or disinfectants are being used and right after their use.
- ☐ Limit use of chemicals that can trigger asthma attacks, such as bleach or ammonium compounds, and do not mix the or use them in enclosed spaces.
- ☐ Use only cleaning products you must use. Some surfaces and objects that are seldom touched may need to be cleaned only with soap and water.

Reference to the Green Cleaning handout

Have you noticed anything that seems to trigger your/your child's asthma?

Have/has you/your child ever had an allergy test?

- ☐ Yes
- ☐ No

mention mold and allergic rhinitis handout

Is there a secondary household where you/your child spends time regularly? (Grandparents' house, other parent's house, etc)

- ☐ Yes
- ☐ No
- ☐ <3 months
- ☐ 3-6 months
- ☐ 6 months-1 year
- ☐ 1-3 years
- ☐ >3 years

How long have you lived at this address?

Has your/your child's asthma symptoms changes since moving to this address?

- ☐ Yes
- ☐ No

When did you/your child last have symptoms?

Asthma Health Care Utilization: Past 3 Months

How would you rate your/your child's asthma during the past 3 months?

- ☐ out of control
- ☐ poorly controlled
- ☐ somewhat controlled
- ☐ well controlled
- ☐ I don't know

In the past 3 months how many days of work/school/daycare have/has you/your child missed due to asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ greater than 5

In the past 3 months, how often did your/your child's asthma keep you from getting as much work done? (at home, work, or school)

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ greater than 5

In the last 3 months, how many days have/has you/the child been working harder to breathe?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ greater than 5

In the last 3 months, how many days did asthma symptoms wake you/your child up in the middle of the night or earlier than usual in the morning?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ greater than 5

In the past 3 months, how many times has your/your child's asthma caused you to call your doctor?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ greater than 5

In the past 3 months, how many times has your/your child's asthma caused you to go to the Emergency Room or Urgent Care Clinic?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ greater than 5

In the past 3 months, besides emergency room/urgent care visits, how many times has your/your child's asthma caused you to go to your doctor's office or clinic for worsening of symptoms?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ greater than 5

In the past 3 months, how many times have/has you/your child been admitted overnight in a hospital due to asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ greater than 5

How many times have/has you/your child EVER in his/her lifetime been to the ER/UCC as a result of asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ < 5

In the past month how many days did your child's asthma keep you from performing normal daily activities (at home, work or school)?

How do the following affect your/your child's asthma symptoms?

Humidity:

- ☐ Improves symptoms
- ☐ No change
- ☐ Makes symptoms worse

Air Conditioning

- ☐ Improves symptoms
- ☐ No change
- ☐ Makes symptoms worse

Medical Information

Here is where referring to the OLOL Asthma Handbook may be the most helpful

Who is the primary care physician?

phone number

PCP Address

How long have/has you/your child been seeing this doctor?

Additional asthma or allergy related specialists:

Do you use a Controller Medication?

- ☐ Yes
- ☐ No

Completed education on Controller medication?

- ☐ Yes
- ☐ No

Do you have a quick relief medication?

☐ Yes☐ No

Completed education on Quick Relief Meds?

☐ Yes☐ No

Are you taking any other medications?

☐ Yes☐ No

In the past 6 months how many times have/has you/your child been prescribed Prednisone?

Have you/ your child ever been intubated due to complications with asthma?

☐ Yes☐ No

How would you rate the effectiveness of your/your child's medications? (5=Very Effective and 0=Not Effective)

☐ 0☐ 1☐ 2☐ 3☐ 4☐ 5

Besides medication what else have you found is helpful to your/your child's asthma?

Who administers the child's meds and treatments most often?

Does your child have a prescription (rescue inhaler) at school?

☐ Yes☐ No

Does your child have a spacer at school?

☐ Yes☐ No

How frequently does the patient use the spacer with his/her controller medication?

☐ Never☐ Rarely☐ Sometimes☐ Very Often☐ Always

How frequently does the paient use the spacer with his/her rescue inhaler?

☐ Never☐ Rarely☐ Sometimes☐ Very Often☐ Always

Notes on Medication Utilization

Does you/your child use a peak flow meter?

☐ Yes☐ No

Has your health care provider/doctor/nurse every given you an asthma action plan?

☐ Yes☐ No

Does the asthma patient have health insurance?

☐ Yes☐ No

Level of Intervention Questions

The EPA Checklist should be explained here. You do not need to collect the answers from the whole checklist just what is listed below.

Do you have a working vacuum?

☐ Yes☐ No

Does the home have wall to wall carpet?

☐ Yes☐ No

Do you have a kitchen hood above your stove that vents to the outside?

☐ Yes☐ No

Do you have a kitchen exhaust fan or a window in the kitchen that opens?

☐ Yes☐ No

Do you use a dust mite allergy mattress cover on your bed?

☐ Yes☐ No

What size mattress do you have?

Are you aware of Air Quality Index (AQI) and the Air Quality "Alert" Days from EPA?

How can you protect yourself when the outdoor air quality is poor?

AQI:
Demonstration of how to use the app with the AQI value of the day.
Make sure the family has signed up for the text alerts and has the app downloaded

SEET hotline
Please make sure that the family has the SEET hotline number (888) 293-7020
They may use this number to contact us for any concerns they have about their indoor health.

What school does your child attend?
Schools name and address

Date of Virtual Home visit 2
Schedule the next visit now with the patient

* must provide value

- ☐ Yes
- ☐ No
- ☐ Avoid being outside in the afternoon & early evening. That's when air pollution levels are usually highest
- ☐ Do less physical activity. Physical activity increases the amount of air you breathe.
- ☐ Keep doors and windows closed to keep harmful air out of your home
- ☐ Change air filters and run air conditioning in "recirculating mode"
- ☐ All of the above

This is where you should have them look at the Outdoor AQ & Asthma handout

- ☐ Yes
- ☐ No

- ☐ Yes
- ☐ No

Mention asthma class at OLOL

M-D-Y H:M

Form Status

Complete?

Incomplete ▼