Pre-Screen

Case ID	_____
Date Enrolled	_____ (YYYY-MM-DD)
Referring Agency	◯ LDH ◯ Hospital Referral ◯ Clinic Referral ◯ Health Insurance Referral ◯ Medicaid ◯ Other
If from LDH, what is case number?	_____ (case # from LDH)
Staff Assigned	◯ Colette Maser ◯ Chelsea Brown ◯ Angelle Naquin ◯ Runa Bakshi
Patient Name	_____
Name of person completing survey	_____
Relationship to Patient	◯ Self ◯ Parent ◯ Adult Care Giver
Number of residents in the home	_____
How many children, under the age of 16, are in the home?	_____
Phone Number	_____
Alternative Phone	_____
Email address	_____
Home address:	_____ (to mail stuff)
Preferred Contact Method for Study Reminders	◯ phone ◯ email

Primary Language?	_____ (If you use a translator include the ID info here)
Has anyone who spends 3+ days a week or lives in the home (e.g.: a grandparents, sitter, health aid, or the residents themselves) been diagnosed with asthma?	◯ Yes ◯ No

Asthma Control Evaluation

How many times in a typical week have you used a rescue inhaler (e.g. albuterol, Pro-air, Ventolin or Xopenex)?	◯ 0 ◯ 1 ◯ 2 or more (score 1 if used >=2/week)
How many times in a typical week do you awaken at night with asthma symptoms or a cough?	◯ 0 ◯ 1 ◯ 2 or more (score 1 if used >=2/week)
Have you had to fill your rescue medicine (e.g. albuterol, pro-air, Ventolin, or Xopenex) more than 2 times in a year?	◯ Yes ◯ No (score 1 if yes)
Have you had 2 or more Emergency Room visits AND/OR 1 or more Hospitalizations for asthma in the the last six months?	◯ Yes ◯ No (Score 1 if response is yes)
How many days of work days and/or school days (choose one or both) have you missed in the past 4 weeks due to asthma?	☐ 1 day or less of school ☐ 2-5 days of school ☐ more than 5 days of school ☐ 1 day or less of work ☐ 2-5 days of work ☐ more than 5 days of work
Do you suffer from allergies/hay fever (runny nose, itchy eyes, etc.)?	◯ Yes ◯ No (score 1 if yes)
Are there particular place(s) that you find your asthma symptoms have been worse in the past 4 weeks?	☐ Home ☐ Workplace ☐ School ☐ Other (score 1 if home is selected)
If other, please describe	_____

On a scale of 1-5 (where 1= not at all and 5= a lot) how much do you feel ASTHMA has affected your quality of life in the past two weeks?
Consider, for instance, the number of missed work/school days due to asthma, lost productivity, how often you felt limited in your activities (e.g., exercising, running, gardening, cleaning, etc.), and/or how often your mental health has been affected due to asthma (e.g., if you felt sad, depressed, ?left out?, ?different?, anxious or frustrated because of asthma).

1 3 5

(Place a mark on the scale above)

Asthma Control Score

_____
(enter total from answers above)

Environmental Evaluation

In your home, which best describes the level of dust buildup on surfaces?

◯ no dust buildup
◯ slight buildup
◯ moderate buildup
◯ heavy buildup
(score 1 if buildup reported as moderate or heavy)

In the past 30 days have you seen or smelled mold/must, or experienced water leaks/ damage, or drips in your home?

◯ Yes
◯ No
(score 1 if yes)

Do you have a problem with pests (mice, rats, cockroaches, etc.) in your home now, or have you in the past 3 months?

◯ Yes
◯ No
(score 1 if yes)

How is your home heated?

◯ radiators
◯ baseboard heater
◯ fireplace/wood stove
◯ forced hot air (vents)
◯ space heater
◯ other
◯ N/A
(score 1 if fireplace)

How is your home cooled?

◯ central A/C
◯ Fans
◯ window A/C or portable units
◯ evaporative cooler
◯ other
◯ N/A
(score 1 if n/a)

Has anyone smoked in the home in the past 7 days?

◯ Yes
◯ No
(score 1 if yes.)

What type of stove (cook top) do you have?	◯ gas ◯ electric ◯ N/A (score 1 if gas)
Do you open a window or use an exhaust fan when cooking on the stove?	◯ Yes ◯ No ◯ N/A (score 1 if NO or n/a)
Do you have any furry or feathered pets?	◯ Yes ◯ No (score 1 if yes)
Do any of the following chemicals in your home have a strong odor that irritates your asthma?	☐ cleaning products containing bleach or ammonia ☐ air fresheners, scented candles, incense ☐ pesticides ☐ paint products, solvents, glue (if anything marked add +1 to score)
Environmental Risk Score	_____ (enter total from answers above)
Composite Score Virtual Visit > 7 (>3 Asthma and >4 Environmental) (scores < 7 materials provided via email)	_____
Do I have your consent to share your your information with Our Lady of the Lake Hospital so that they may schedule your virtual home visit?	◯ Yes ◯ No
Do I have your consent to email/mail you educational information to help control your asthma by making small changes to your indoor environment?	◯ Yes ◯ No