

Virtual visit 1

Case ID

Initial Virtual Home Visit

Date and time of initial home visit

Name of Interviewer

- Tracy Marquette
 Cheree Duvic
 Chaplis Tiner
 Other

Other Staff assigned

Status of Home Visit

- Successful
 Unsuccessful

If unsuccessful, reason:

- client requested to reschedule
 client refused services (cancelled)
 Client unavailable at home (no show)
 other

Status

- Visit Complete
 No Visit

Reason for no visit

- reschedule
 moved
 dismiss landlord issues
 dismiss insurance issues
 other

other reason for no visit

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

- Yes
 No

First Name

Last Name

Primary number

Alternative Number _____

Address _____

Patient Name _____

(this is who suffers from asthma)

Patient Age _____

**For our virtual visits, which is your first choice of application and how do you rank the others?
We would like to always have a back up method in case the technology is not working**

	First	Second	Third	Fourth
Zoom	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Teams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FaceTime	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Google Hangout	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Household Information

Female Head of Household

- No
 Yes

Total number of persons living in household _____

What is the income level (AMI \$85,600) for this household?

- extremely low income limits (< 30% AMI=\$25,000)
 low income limits (< 50% AMI=\$42,800)
 moderate income limits (< 80% AMI=\$68,480)

Do you like the neighborhood?

- Yes
 No

Do you think this is someplace you would like to stay for a while?

- Yes
 No

Please explain why or why not you would want to stay in in this neighborhood. _____

How many times in the last 12 months have you changed residences?

- none
 1 time
 2 times
 3 times
 4 times
 5 or more times

Do you rent or own?

- Rent
 Own

Do you have a mortgage on the home? Yes
 No

How much is your rent or mortgage per month?

Are you currently late on your rent or mortgage payments? Yes
 No

If you are currently late on rent or mortgage payment, what is the cause?

- Loss of Income
- Reduction in Income
- Medical Issues
- Increase in Expenses
- Divorce/Separation
- Death of Family Member
- Increase in Mortgage Payment
- Budget Management Issues
- Business Venture Failure
- Other

Do you have homeowner's or renter's insurance Yes
 No

Do you receive Section 8 or other housing assistance? Yes
 No

if yes, what program?

Do you live in public housing? Yes
 No

Asthma Questions

Name of patient with asthma

Gender of patient male
 female

date of birth

age of patient at time of visit

Does the person with asthma also have a disability? No
 Yes

Is this person of Hispanic, Latino of Spanish origin? No
 Yes

What is this person's race?

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

If Other specify race/ethnicity

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

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

- 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
- (Use the Indoor Air Pollution and EPA checklist front page for triggers.)

If other please explain

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

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

If Yes, what were the results?

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

- Yes
- No

If yes, please explain any changes in asthma symptoms with the change in environment.

How long have you lived at this address?

- < 3 months
- 3-6 months
- 6 months-1 year
- 1-3 years
- >3 years

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

- Yes
- No

If yes, how?

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:

Does you use a Controller Medication?

- Yes
 No

What type of medication is it?

- Inhaler
 Liquid
 Nasal Spray
 Pill
 Other

What is the Brand of the medication?

How are you meant to take the medication?

Date Filled:

Expiration Date:

Number of Refills:

Are you taking this medication as directed (right dose and on time)?

- Yes--always!
- Yes--most of the time
- Yes, but sometimes I don't/can't
- Most of the time I don't/ can't
- I almost never do/ can

Does you have a quick relief medication?

- Yes
- No

What type of medication is it?

- Inhaler
- Liquid
- Nasal Pray
- Pill
- Other

What is the brand of the medication?

How are you meant to take the medication?

Date Filled:

Expiration Date:

Number of Refills:

Are you taking this medication as directed (right dose and on time)?

- Yes--always!
- Yes--most of the time
- Yes, but sometimes I don't/can't
- Most of the time I don't/can't
- I almost neve do/can

Are you taking any other medications?

- Yes
- No

Please list all other medications

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

if yes, when was this? _____

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 patient 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

If yes, when? _____

Does the asthma patient have health insurance? Yes
 No

What kind of insurance? Medicaid
 Private Insurance
 Amerigroup
 United Health Care
 Blue Cross Blue Shield
 Aetna
 Other

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

What kind (brand)? _____

Does it have a HEPA filter? 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

Does you use a dust mite allergy mattress cover on your bed? Yes
 No

What size mattress do you have? single
 twin
 full
 queen
 king
 other

If other, please specify: _____

Are you aware of Air Quality Index (AQI) and the Air Quality "Alert" Days from EPA? Yes
 No

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

- 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)

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

- Yes
- No

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.

- Yes
- No
(Mention asthma class at OLOL)

What school does your child attend?
Schools name and address

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