



BREATH OF FRESH AIR PROGRAM

STAMFORD DEPARTMENT OF HEALTH & SOCIAL SERVICES
STANDARDIZED ASSESSMENT INSTRUMENT

Registration via: Letter _____ Follow-up call _____ Follow-up home visit _____ Referral _____ Other _____

School _____

Date _____

1. DEMOGRAPHICS:

Child's Name: _____ M F

Mother's Name: _____ Race/ Ethnicity: W B H A O

Address: _____ Birthdate: _____

Emergency Contact: _____ Telephone: _____

Primary Care Physician: _____ Date of last visit: _____

Name of Physician your child sees for Asthma: _____ Date of last visit: _____

Babysitter/Caregiver: Yes No If yes, where? Private Residence School Comm. Ctr Other

If private home, history of smoking? Yes No

Health Insurance: None Private HUSKY/Medicaid

Prescription Drug Coverage Yes No Co-Pay Yes No

Family History of Asthma : Yes No Family History of Allergies: Yes No

Primary Language spoken at home: _____ How many children living in household: _____

2. RISK:

High Risk

Date of Most Recent Event

- Previous ICU Admissions Yes No Don't Know _____
- Previous intubations Yes No Don't Know _____
- 6 or more courses of oral steroids per year Yes No Don't Know _____
- 6 or more canisters of Albuterol per year Yes No Don't Know _____

Moderate Risk

Date of Most Recent Event

- Previous ER visits Yes No Don't Know _____
- Has your child ever been hospitalized overnight Yes No Don't Know _____
- 3 or more courses of oral steroids per year Yes No Don't Know _____

Low Risk

- None None of the above risk factors



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3. MEDICATIONS:

Controllers	√	Dose	Freq	Controllers	√	Dose	Freq	Quick-Relief	√	Dose	Freq
<u>Inhaled</u> <u>Coricosteroids</u>				<u>Mast Cell</u> <u>Stabilizers</u>				<u>Short-acting</u> <u>Beta-agonist</u>			
Fluticasone				Cromolyn neb. soln. 20 mg/amp				Albuterol MDI 90 mcg			
<i>Flovent</i> MDI 44 mcg				<i>Intal</i> MDI 800 mcg				<i>Proventil</i> MDI 90 mcg			
<i>Flovent</i> MDI 110 mcg				Tilade 1.75 mg/MDI				<i>Ventolin</i> MDI 90 mcg			
<i>Flovent</i> MDI 220 mcg				<u>Anti-Leukotrienes</u>				Maxair 0.2 mg/MDI			
<i>Flovent</i> DPI 50 mcg				Montelukast				Albuterol neb. soln. 2.5mg/3ml prediluted			
<i>Flovent</i> DPI 100 mcg				<i>Singulair</i> 4 mg chew.				Albuterol 0.5% soln. Dilute for neb with			
<i>Flovent</i> DPI 250 mcg				<i>Singulair</i> 5 mg chew.				Levalbuterol			
Budesonide				<i>Singulair</i> 10 mg tab.				<i>Xopenex</i> 0.63mg/3ml neb. soln.			
<i>Pulmicort</i> Respules 0.25 mg/2ml								<i>Xopenex</i> 1.25mg/3ml neb. soln.			
<i>Pulmicort</i> Respules 0.50 mg/2ml				<u>Long-acting</u> <u>Bronchodilators</u>				Oral Steroids			
<i>Pulmicort</i> Turb. 200 mcg				Salmeterol				Prednisone			
Beclomethasone				<i>Serevent</i> MDI 21 mcg				5 mg			
<i>Vanceril</i> 42 mcg				<i>Serevent</i> DPI 50 mcg				10 mg			
<i>Beclovent</i> 42 mcg								20 mg			
<i>QVAR</i> MDI 40 mcg				<u>Combination</u> <u>Drugs</u>				Prednisolone			
<i>QVAR</i> MDI 80 mcg				<i>Advair</i> Diskus Fluticasone + Salmeterol				<i>Pediapred</i> 5mg/5ml			
Triamcinolone				100mcg Flut/50 Sal				<i>Prelone</i> 15mg/5ml			
<i>Azmacort</i> 100 mcg				250mcg Flut/50 Sal				<i>Orapred</i> 15mg/5ml			
				500mcg Flut/50 Sal				Theophlline prep			

Other _____



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4. ASTHMA CONTROL QUESTIONNAIRE[®]:

1. On average, during the past week, how often were you **awoken by your asthma** during the night?

- 0 Never
- 1 Hardly ever
- 2 A few times
- 3 Several times
- 4 Many times
- 5 A great many times
- 6 Unable to sleep because of asthma

2. On average, during the past week, how **bad were your asthma symptoms when you woke up** in the morning?

- 0 No symptoms
- 1 Very mild symptoms
- 2 Mild symptoms
- 3 Moderate symptoms
- 4 Quite severe symptoms
- 5 Severe symptoms
- 6 Very severe symptoms

3. In general, during the past week, how **limited were you in your daily activities** because of your asthma?

- 0 Not limited at all
- 1 Very slightly limited
- 2 Slightly limited
- 3 Moderately limited
- 4 Very limited
- 5 Extremely limited
- 6 Totally limited

4. In general, during the past week, how much **shortness of breath** did you experience because of your asthma?

- 0 None
- 1 Very little
- 2 A little
- 3 A moderate amount
- 4 Quite a lot
- 5 A great deal
- 6 A very great deal

5. In general, during the past week, how much of the time did you **wheeze**?

- 0 Not at all
- 1 Hardly any of the time
- 2 A little of the time
- 3 A moderate amount of the time
- 4 A lot of the time
- 5 Most of the time
- 6 All the time



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5. NHLBI ASTHMA SEVERITY INDEX

Day Time Symptoms	Daily Activity	Night Time Symptoms	FEV1/PEF	NHLBI Severity Index
Continuous <input type="checkbox"/>	Interferes with any activity <input type="checkbox"/>	Frequently <input type="checkbox"/>	≤ 60%	Severe Persistent
Daily <input type="checkbox"/>	Interferes with moderate activity <input type="checkbox"/>	Over 5x/month <input type="checkbox"/>	> 60% < 80%	Moderate Persistent
3-6x/week <input type="checkbox"/>	Only with a lot of activity <input type="checkbox"/>	3-4x/month <input type="checkbox"/>	≥ 80%	Mild Persistent
0-2x/week <input type="checkbox"/>	Not at all unless an attack <input type="checkbox"/>	Under 2x month <input type="checkbox"/>	≥ 80%	Mild Intermittent

6. ADEQUACY OF ASTHMA TREATMENT:

Compliance with Medications:

Always uses medications as prescribed: Yes No Don't Know **If No, 2 pts** _____
 If not, why not: _____
 How long does your inhaler last? _____

Treatment Plan:

Does your child have an asthma management plan so you know what to do

- On a Daily Basis Yes No Don't Know **If No, 2 pts** _____
- If your child's asthma gets worse Yes No Don't Know **If No, 2 pts** _____

Use of Spacers/Inhalers:

Does your child use a spacer with an MDI Yes No Don't Know DNH **If No, 1 pt** _____
 Is your child using the inhaler properly? Yes No Don't Know DNH **If No, 1 pt** _____
 Do you use a nebulizer at home? Yes No Don't Know DNH **If No, 1 pt** _____

Use of Peak Flow Meter:

Does your child use a peak flow meter? Yes No Don't Know DNH
 Do you know your child's his/her number? Yes No Don't Know **If No, 1 pt** _____

Allergy Testing:

Has your child ever been tested for allergies?
 Yes No Don't Know Allergic to: _____

Seasonal Allergy Symptoms (nasal congestion watery eyes sneezing)

Are the allergy symptoms under control adequately Yes No Don't Know **If No, 2 pts** _____ **TOTAL** _____

Treatment Very Poor 10-12 Poor 7-8 Fair 4-6 Good 2-3 Excellent 0-1



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PARENT QUIZ

7. PARENT'S KNOWLEDGE OF ASTHMA:

Do you or members of your family smoke? Yes No Don't Know [If Yes, 3 pts] _____

If yes, where is smoking done? (Please **circle** all applicable choices) Indoors Outdoors Cars

How many cigarettes/cigars do you smoke in a day? _____

Do you have a cat or dog ? Yes No Don't Know [If Yes, 2 pts] _____

If yes, does the pet sleep in your child's room? Yes No Don't Know

Do you use a pillow and mattress cover? Yes No Don't Know

Do you wash bed linens in hot water? Yes No Don't Know

Do you use a humidifier/vaporizer? Yes No Don't Know [If Yes, 1 pt] _____

Are there stuffed animals on your child's bed? Yes No Don't Know [If Yes, 1 pt] _____

Total Score _____

[Parent Quiz Score - Possible 5 Pts] _____

[Parent Asthma Self Management Confidence Scale Score - Possible 18 Pts] _____

TOTAL PARENTAL KNOWLEDGE SCORE [Add above lines] _____

The following **TRUE** or **FALSE** statements test what you know about asthma

- | | TRUE | FALSE |
|---|-------------|--------------|
| 1. The way that parents raise their children can cause asthma. | _____ | _____ |
| 2. Many different things can bring on an asthma episode. | _____ | _____ |
| 3. There are different types of medicine to control asthma. | _____ | _____ |
| 4. Both children and adults can have asthma. | _____ | _____ |
| 5. People with asthma should not exercise. | _____ | _____ |
| 6. Asthma can be cured. | _____ | _____ |
| 7. Children outgrow asthma. | _____ | _____ |
| 8. All pet allergens will be cleared from a room once a pet is removed. | _____ | _____ |
| 9. Secondhand smoke may cause the development of asthma in pre-school children. | _____ | _____ |
| 10. People with asthma should avoid all known asthma triggers. | _____ | _____ |

½ point for each correct answer

TOTAL SCORE= _____/5



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PARENT ASTHMA SELF MANAGEMENT CONFIDENCE SCALE

How confident are you that:	Very Sure	Somewhat Sure	Not at all Sure
1. You can keep (child's name) from having asthma symptoms such as wheezing or coughing.	1	2	3
2. If (child's name) starts to have asthma symptoms such as wheezing or coughing, you can keep these symptoms from getting worse.	1	2	3
3. When (child's name) has asthma symptoms you can make symptoms stop without having to call or visit the doctor.	1	2	3
4. In general, you can take care of (child's name) asthma.	1	2	3
If child is older than 5 ask:			
5. (Child's name) can keep from having asthma symptoms such as wheezing or coughing all by him/herself.	1	2	3
6. If (child's name) starts to have asthma symptoms such as wheezing or coughing, he/she can keep these symptoms from getting worse all by him/herself.	1	2	3

*Clark, N.M., Gong, M. Kaciroti, N.A. model of self-regulation for control of chronic disease. *Health Education & Behavior* 28(6): 769-782.2000.

Knowledge Very Poor 25-30 Poor 19-24 Fair 13-18 Good 7-12 Excellent 0-6

CHILD'S KNOWLEDGE OF ASTHMA:

- | | | | |
|--|------------------------------|-----------------------------|------------------------------|
| Demo of Peak Flow Meter: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DNH <input type="checkbox"/> |
| Demo of Inhaler: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DNH <input type="checkbox"/> |
| Is Inhaler used correctly? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If no, 2 pts _____ |
| Is Peak Flow Meter used correctly? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If no, 2 pts _____ |
| Do you know your symptoms of an asthma attack? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If no, 3 pts _____ |
| Have you been to "Open Airways?" | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Have you taken classes at TSH? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Have you been to "Camp Treasure Chest?" | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Have you been to "Any Info Classes?" | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Other? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | TOTAL pts ____/7 |



ASTHMA TRIGGERS

Knowing your triggers can help you manage your asthma symptoms and prevent attacks. You may have many asthma triggers, or just a few.

9. ASTHMA TRIGGER EDUCATION CHECKLIST:

- | | |
|---|--|
| <input type="checkbox"/> Mold and mildew | <input type="checkbox"/> Household or occupational chemicals |
| <input type="checkbox"/> Cigarette smoke or air pollution | <input type="checkbox"/> Carpeting |
| <input type="checkbox"/> Dust, dust mites, mold or mildew | <input type="checkbox"/> Rodents |
| <input type="checkbox"/> Cockroaches | <input type="checkbox"/> Strong emotions/stress |
| <input type="checkbox"/> Pets with feathers, fur or hair | <input type="checkbox"/> Perfume |
| <input type="checkbox"/> Heating and cooling systems | <input type="checkbox"/> Change of residence |
| <input type="checkbox"/> Humidifier | <input type="checkbox"/> Vigorous activity |
| <input type="checkbox"/> Colds, or sinus infections | <input type="checkbox"/> Stuffed animals in bedroom |
| <input type="checkbox"/> Pollen of trees, grasses or weeds | <input type="checkbox"/> Wind, high humidity or cold weather |
| <input type="checkbox"/> Exhaust fumes and irritants such as hair spray or paint | <input type="checkbox"/> Aspirin or ibuprofen |
| <input type="checkbox"/> Foods such as nuts, shrimp, or those containing sulfites | |

