**FOLLOW UP CALL**

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**The purpose of this interview is to collect information about you and your home environment as it relates to your asthma and safety. These questions are to guide the type of help you will receive. You do not have to answer any questions you do not want to. All of your responses are confidential and will not affect any of the services at the clinic or from your provider.**

**ASSESSOR**

**A. Explain reason for follow up call:**

1. Ensure client is doing well managing asthma

2. Answer any questions family/client may have.

**B. Assess whether family needs or wants an asthma follow up home visits.**

**C. Explain what “well controlled” means.**

Asthma patients are considered to have

“Well controlled asthma” when:

1. Daytime symptoms are fewer than two days per week ***AND***

2. Waking up at night from asthma symptoms occurs less than two times a month ***AND***

3. There are no limitations of activities

**1. Does the person with asthma have their asthma?**

**“Well controlled”?**

*  No  Yes **2. Questions for Client with Asthma – Follow Up Call**

|  |  |
| --- | --- |
| During the past **4 weeks, how many days of school/daycare/ work** were missed due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| During the past **4 weeks, how many work days** did **Parent** miss due to child's asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| Since **1st Home visit, how many times** has client been hospitalized due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| Since **1st Home visit, how many times** has client visited the Emergency Room due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| Since **1st Home visit, how many times** has client visited Urgent Care or had a same day visit with provider due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| During the past **week, how many times** did client use Albuterol? | **4+ 3 2 1 0**  ***(Circle One)*** |
| During the past **week, how many times** did client wake due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| During the past **4 weeks, has the client’s** activity been reduced due to asthma? | **Yes No**  ***(Circle One)*** |
| If Yes, Explain: |  |

|  |  |
| --- | --- |
| **Assessor Name 1:** | |
| **Client Name:** | **Call Date:** |