Appendix 7: Hawaii CARES Encounter Form

Have you signed this consent form before? ☐ No ☐ Yes Best time to call?_____
If declined consent, state why:_____ Phone 1:_____ 2:_____

Name BD Gender MR# Site_____ Date:_____

SYMPTOMS BRINGING YOUR CHILD TO THE ER

# of days your child has been coughing?____ wheezing?_____ had trouble breathing?_____

SIGNS PRESENT IN ER

Admission: Heart Rt: ____ Resp. Rt: ____ Osat (RA): ____ Peak Flow:____(L/min) Height:____ (in)

Using accessory muscles, suprasternal retractions:
- ☐ not using accessory muscles or retracting
- ☐ using accessory muscles and retracting
- ☐ demonstrating paradoxical thoracoabdominal movement

Wheeze:
- ☐ not heard, clear lungs
- ☐ only at end expiration
- ☐ heard throughout expiration
- ☐ loud & heard throughout inspiration & expiration
- ☐ tight, so severe not heard

THIS PEAK FLOW SECTION ONLY FOR CHILDREN 7-17 YEARS OLD

Do you have a peak flow meter? ☐ No ☐ Yes Use peak flow meter at home?: ☐ Daily ☐ As Needed ☐ Never

MEDICATION IN USE WITHIN 24 HOURS OF THIS ER VISIT:

	Medication (☐ Check if took no meds, then skip to Past Asthma History Section)	Route (check one or more) PO	inhaler	inhaler + spacer	Neb	In last 12 hours how many times used?	When does [child] really take medication? (check one) Only when sick	Always, even when well
Beta-Agonists	Albuterol, Ventolin, Proventil	☐	☐	☐	☐	_____	☐	☐
	Serevent, salmeterol	☐	☐	☐	☐	_____	☐	☐
	Ipatropium, Atrovent	☐	☐	☐	☐	_____	☐	☐
	levalbuterol, Xopenex	☐	☐	☐	☐	_____	☐	☐
	Maxair	☐	☐	☐	☐	_____	☐	☐
	Combivent	☐	☐	☐	☐	_____	☐	☐
	Epinephrine, Primatene	☐	☐	☐	☐	_____	☐	☐
	Terbutaline, Brethine	☐	☐	☐	☐	_____	☐	☐
	Alupent, metaproteronol, Metaprel	☐	☐	☐	☐	_____	☐	☐
Corticosteroids	Pulmicort, budesonide	☐	☐	☐	☐	_____	☐	☐
	Azmacort, triamcinolone	☐	☐	☐	☐	_____	☐	☐
	Flovent, fluticasone, Nasalide, flunisolide, flunisolone	☐	☐	☐	☐	_____	☐	☐
	Advair	☐	☐	☐	☐	_____	☐	☐
	Prednisone, Deltasone, prednisolone, Pediapred, Prelone, dexamethasone, Decadron	☐	☐	☐	☐	_____	☐	☐
Other	Accolate, zafirlukast Singulair montelukast, Zyflo	☐	☐	☐	☐	_____	☐	☐
	Cromolyn, Intal, Tilade	☐	☐	☐	☐	_____	☐	☐
	Other, Specify_____	☐	☐	☐	☐	_____	☐	☐

PAST ASTHMA HISTORY

# of ER visits for asthma in past 4 months:____ past 12 months:____ # of office visits for asthma past 4 months:____ past 12 months:____

# of hospital admissions in past 12 months:_____ When was the last overnight hospital adm. because of asthma? ☐ <1 day ago ☐ <1 week ☐ <1 month

Asthma Written Action Plan? ☐ No ☐ Yes Patient's Physician: _____ ☐ <1 yr. ☐ >1 yr. ☐ Never
(this is a written action plan made by you and your [child's] doctor to help care for your [child's] asthma).

HOME ASSESSMENT

1. **Think about the past 2 months... does your child usually cough, wheeze, or have trouble breathing during the day more than 2 times a week?**

☐ No ☐ Yes → Is it every day, all day long?
☐ No ☐ Yes → Is it once a day, every day? ☐ No ☐ Yes

2. **Think about the past 2 months... does your child usually cough, wheeze, or have trouble breathing during the night more than 2 times a month?**

☐ No ☐ Yes → Is it 3 or more nights per week?
☐ No ☐ Yes → Is it more than one night per week? ☐ No ☐ Yes

MEDS GIVEN IN ER: ☐ check if admitted to hospital (from this ER visit)

# of Beta Agonist ___ ☐ With ☐ Without Atrovent corticosteroid in ER: ☐ PO ☐ IM ☐ IV ☐ inhaled

AT DISCHARGE FROM ER: Final ER Diagnosis:_____ Discharge Peak Flow:____

New Meds prescribed at discharge: _____ _____ _____ Discharge Osat (RA)____

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