

Appendix 7: Hawaii CARES Encounter Form

Have you signed this consent form before? <input type="checkbox"/> No <input type="checkbox"/> Yes Best time to call? _____				Name <u> </u> BD <u> </u> Gender <u> </u> MR# <u> </u> Site <u> </u> Date: <u> </u>					
If declined consent, state why: _____				Phone 1: _____ 2: _____					
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: Wheeze: <input type="checkbox"/> not heard, clear lungs									
<input type="checkbox"/> not using accessory muscles or retracting		<input type="checkbox"/> only at end expiration							
<input type="checkbox"/> using accessory muscles and retracting		<input type="checkbox"/> heard throughout expiration							
<input type="checkbox"/> demonstrating paradoxical thoracoabdominal movement		<input type="checkbox"/> loud & heard throughout inspiration & expiration							
		<input type="checkbox"/> tight, so severe not heard							
THIS PEAK FLOW SECTION ONLY FOR CHILDREN 7-17 YEARS OLD									
Do you have a peak flow meter? <input type="checkbox"/> No <input type="checkbox"/> Yes Use peak flow meter at home?: <input type="checkbox"/> Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Never									
MEDICATION IN USE WITHIN 24 HOURS OF THIS ER VISIT:									
Medication <input type="checkbox"/> Check if took no meds, then skip to Past Asthma History Section			Route (check one or more)				In last 12 hours how many times used?	When does [child] really take medication? (check one)	
			PO	inhaler	inhaler + spacer	Neb		Only when sick	Always, even when well
Beta Agonists	Albuterol, Ventolin, Proventil		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Serevent, salmeterol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Ipratropium, Atrovent		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	levalbuterol, Xopenex		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Maxair		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Combivent		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Epinephrine, Primatene		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Terbutaline, Brethine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Alupent, metaproteronol, Metaprel		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
Corticosteroids	Pulmicort, budesonide		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Azmacort, triamcinolone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Flovent, fluticasone, Nasalide, flunisolide, flunisolone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Advair		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Prednisone, Deltasone, prednisolone, Pediapred, Prelone, dexamethasone, Decadron		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other	Accolate, zafirlukast		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Singulair montelukast, Zytlo		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Cromolyn, Intal, Tilade		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
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? <input type="checkbox"/> <1 day ago <input type="checkbox"/> <1 week <input type="checkbox"/> <1 month									
Asthma Written Action Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes Patient's Physician: _____ <input type="checkbox"/> <1 yr. <input type="checkbox"/> >1 yr. <input type="checkbox"/> 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 <u>during the day</u> more than 2 times a <u>week</u> ?									
<input type="checkbox"/> No <input type="checkbox"/> Yes →		Is it every day, all day long?							
		<input type="checkbox"/> No <input type="checkbox"/> Yes →		Is it once a day, every day? <input type="checkbox"/> No <input type="checkbox"/> Yes					
2. Think about the past 2 months... does your child usually cough, wheeze, or have trouble breathing <u>during the night</u> more than 2 times a <u>month</u> ?									
<input type="checkbox"/> No <input type="checkbox"/> Yes →		Is it 3 or more nights per week?							
		<input type="checkbox"/> No <input type="checkbox"/> Yes →		Is it more than one night per week? <input type="checkbox"/> No <input type="checkbox"/> Yes					
MEDS GIVEN IN ER: <input type="checkbox"/> check if admitted to hospital (from this ER visit)									
# of Beta Agonist _____ <input type="checkbox"/> With <input type="checkbox"/> Without Atrovent corticosteroid in ER: <input type="checkbox"/> PO <input type="checkbox"/> IM <input type="checkbox"/> IV <input type="checkbox"/> inhaled									
AT DISCHARGE FROM ER: Final ER Diagnosis: _____ Discharge Peak Flow: _____									
New Meds prescribed at discharge: _____ Discharge Osat (RA) _____									

doi:10.1542/peds.2005-2000U

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Pediatrics 2006;117;S192

DOI: 10.1542/peds.2005-2000U

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