Appendix 5: Michigan Child Cohort Visit Form

Visit Form Cohort Child/Version: 8/06/01

Pt. initials __ __ __

Patient Study Number __ - __ __ __

Interviewer's initials __ __ __

Emergency Department (CIRCLE ONE):

Gerber **Blodgett** **Butterworth**

ED visit date (mm/dd/yr) __ / __ / __

ED triage time (hh:mm) ___ / ___

Insurance Company _____

Presenting complaint _____

PLEASE ANSWER EVERY QUESTION. IF PARENT DOES NOT KNOW AN ANSWER PLEASE WRITE IN 'DK' (DON'T KNOW). RECORD ONLY ONE ANSWER TO EACH QUESTION UNLESS SPECIFICALLY INSTRUCTED TO 'CHECK ALL THAT APPLY'.

A. DEMOGRAPHIC INFORMATION

1. Date of child's birth (mm/dd/yr) __ / __ / __

2. Sex: Male 01
   Female 02

3. Is your child Spanish, Hispanic or Latino?

   No 01
   Yes 02

4. What race is your child? (SELECT ONE OR MORE)

   White or Caucasian 01
   Black or African-American 02
   Asian 03
   American Indian or Alaska Native 04
   Native Hawaiian or Pacific Islander 05
   Other race, please specify: _____ 06

5. How much schooling have **you** (parent or guardian) completed?
   Less than high school 01
   Graduated high school or got GED 02
   1-3 years of college 03
   4-year college degree or more 04

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B. ASTHMA HISTORY

6. Has a doctor **ever** told you that your child has asthma?

No.....01
Yes.....02

If Yes, 6a. How old was your child when a doctor first diagnosed him/her with asthma?

< 2 years old.....01
2 - 5 years.....02
5 - 9 years.....03
10 - 14 years.....04
15 - 18 years.....05

The following questions are about your child's asthma symptoms over the last 4 weeks that is from _____ to _____ (but do not refer to this current episode)

7. How often in the last 4 weeks has your child had asthma symptoms **during the day**? (i.e., wheezing, a dry cough, shortness of breath, and/or chest tightness)

Never.....01
Less than once a week.....02
1 or 2 times a week.....03
3 to 6 times a week.....04
Every day.....05
Continually (all the time).....06

8. How many times over the last 4 weeks did your child **wake up at night** because of asthma symptoms? (i.e., wheezing, a dry cough, shortness of breath, and/or chest tightness)

Never.....01
1 or 2 times.....02
3 to 4 times.....03
5 to 9 times.....04
10 or more times.....05

9. How many times over the last 4 weeks has your child's activities been **affected or restricted** by his/her asthma symptoms?

Never.....01
1 or 2 times.....02
3 to 4 times.....03
5 or more times.....04
All the time.....05

10. In the last 4 weeks has your child's asthma symptoms ever been severe enough to limit your child's speech to **only 1 or 2 words** at a time between breaths?

No.....01
Yes.....02

If Yes, 10a. How many times has this occurred in the last 4 weeks? _____

C. USUAL SOURCE OF ASTHMA CARE

11. Does your child have a "primary care provider" or other regular source of medical care (such as a family doctor, pediatric nurse practitioner or medical clinic)?

No (IF NO, SKIP TO QUESTION 13).....01
Yes.....02

12. Does this doctor/provider/clinic take primary responsibility for your child's regular **asthma care**? (i.e., directs your child's asthma care and writes most of your prescriptions)
[= REGULAR ASTHMA CARE PROVIDER]

No.....01
Yes (IF YES, SKIP TO QUESTION 14).....02

13. What type of doctor/provider/clinic takes primary responsibility for your regular **asthma care**? (i.e., directs your child's asthma care and writes most of your prescriptions)
[= REGULAR ASTHMA CARE PROVIDER]

Emergency Department (specify: _____).....01
Med center (= urgent care center) (specify: _____).....02
An asthma specialist (specify pulmonologist, allergist,
or asthma clinic _____).....03
Other provider/site (specify: _____).....04
No regular asthma care provider (SKIP TO QUESTION 16).....05

14. How many times in the last 12 months did your child visit this (doctor/provider/clinic) for a regularly scheduled appointment for asthma care?
[SCHEDULED APPT. = REGULAR OR ROUTINE VISIT TO DISCUSS ASTHMA]

_____ times or Never

15. How many months ago was the last regularly scheduled appointment for asthma care with this doctor/provider/clinic?

≤ 1 month ago.....01
1 – 3 months ago.....02
4 - 6 months ago.....03
7 – 12 months ago.....04
> 12 months ago.....05

16. In the last 12 months, has your child visited an asthma specialist (e.g., pulmonologist, allergist, asthma clinic or other specialist)? (LEAVE BLANK IF SPECIALIST IS REGULAR ASTHMA CARE PROVIDER AS DEFINED IN QUESTION 13).

No 01
Yes 02

D. CURRENT ASTHMA TREATMENT, MANAGEMENT AND CONTROL

17. RECORD ALL PRESCRIPTION AND NON-PRESCRIPTION ASTHMA RELATED MEDICATIONS USED IN THE LAST 4 WEEKS IN THE FOLLOWING TABLE (EXCEPT SYSTEMIC STEROIDS – SEE QUESTION 18)

Medication (name)	Frequency Doctor Rx'd	Current Frequency of Use	Route	Has Rx Run Out?	Used in last four weeks?
	Daily QOD weekly PRN	Daily QOD Weekly PRN	PO Inh Neb	Yes No	Yes No
	Daily QOD weekly PRN	Daily QOD Weekly PRN	PO Inh Neb	Yes No	Yes No
	Daily QOD weekly PRN	Daily QOD Weekly PRN	PO Inh Neb	Yes No	Yes No
	Daily QOD weekly PRN	Daily QOD Weekly PRN	PO Inh Neb	Yes No	Yes No
	Daily QOD weekly PRN	Daily QOD Weekly PRN	PO Inh Neb	Yes No	Yes No
	Daily QOD weekly PRN	Daily QOD Weekly PRN	PO Inh Neb	Yes No	Yes No
	Daily QOD weekly PRN	Daily QOD Weekly PRN	PO Inh Neb	Yes No	Yes No

18. Has your child ***ever*** taken steroids orally or by injection for a severe asthma attack?

No 01
Yes 02

If Yes, 18a. **Over the past 4 weeks**, has child taken any steroids orally or by injection for asthma? (CHECK ORAL AND INJECTION IF HAVE TAKEN BOTH)

No 01
Yes – Injection 02
Yes – Oral 03

If Yes - Oral,

18b. How many days in the past 4 weeks did child take oral steroids? _____ days

18c. How many days ago did child last take oral steroids? _____ days

IF CHILD NOT CURRENTLY USING INHALED CORTICOSTEROIDS:

19. Has child ever used an inhaled steroid for asthma?

No.....01
Yes.....02

If Yes,

19a. Names (s) _____

19b. For how long did child take an inhaled steroid for asthma?

_____ weeks / months / years.

19c. When did child last use an inhaled steroid for asthma?

_____ months / years ago.

20. Are you usually able to get your asthma prescriptions filled?

No.....01
Yes.....02

If No, 20a. Why not? Specify main reason _____

21. A spacer is a device that you put between the mouth and inhaler to make it easier to breathe medicine into the lungs. Does your child have a spacer?

No.....01
Yes.....02

If Yes, 21a. How often does child use the spacer when using the inhaler?

Never.....01
Rarely.....02
Occasionally.....03
Usually.....04
Always.....05

22. A peak flow meter measures how hard you can blow air out of the lungs. Does your child have a peak flow meter?

No.....01
Yes.....02

If Yes, 22a. On average, how often does your child use the peak flow meter?

Rarely.....01
< 1/week.....02
1-3/week.....03
4-6/week.....04
Daily.....05
Only during exacerbations.....06

23. Has a doctor or a nurse ever given you a written plan for you to treat your child's asthma? [= ASTHMA ACTION PLAN]

No.....01
Yes.....02

24. Have you or your child ever received education about asthma control and treatment from a health professional?

No.....01
Yes.....02

If Yes, 24a. What did you learn about (CIRCLE YES OR NO FOR EACH ITEM):

Things that can trigger your asthma?	YES	NO
Medications and treatments?	YES	NO
How to use an inhaler or nebulizer?	YES	NO
How to use a peak flow meter?	YES	NO
What to do during an asthma attack?	YES	NO
How to use a written action plan?	YES	NO

E. EMERGENCY ASTHMA CARE

[THE FOLLOWING ANSWERS SHOULD NOT INCLUDE THE CURRENT EPISODE]

25. Has your child **ever** been hospitalized overnight for treatment of asthma symptoms [i.e., wheezing, dry cough, shortness of breath, and/or chest tightness]?

No.....01
Yes.....02

If Yes, 25a. How many times in the last 12 months, did your child stay over night in the hospital for treatment of asthma symptoms?

_____ times

26. Excluding today, has your child ever previously gone to an emergency room for urgent treatment of asthma symptoms?

No.....01
Yes.....02

If Yes, 26a. How many times in the last 12 months, did your child visit an emergency room for urgent treatment of asthma symptoms?

_____ times

26b. Which emergency rooms did your child visit?

_____

26c. How long ago was the last visit? _____ days / weeks / months ago

27. When your child is having problems with asthma symptoms that requires **urgent** treatment - that is, treatment needed within 24 hours of recognizing a problem, where do you usually end up taking him/her?

Regular asthma care provider (as defined previously)
SKIP TO QUESTION 28.....01
Emergency Department (if after hours or RACP is NA).....02
(specify: _____)
Emergency department (ALL times) specify: _____).03
Med care center (specify: _____).....04
An asthma specialist (specify pulmonologist, allergist, or asthma clinic: _____).....05
Other provider/site (specify: _____).....06
No specific location/provider.....07

If answer is NOT regular asthma care provider then:

27a. Why do you use this particular place for asthma care? (CHECK ALL THAT APPLY)

No regular asthma care provider.....01
Regular asthma care provider not available.....02
Insurance company dictates.....03
No insurance.....04
Other cost issues (specify: _____).....05
Transport issues (specify: _____).....06
Convenience.....07
Best medical care.....08
Past experience/comfort with people/place.....09
Other (specify: _____).....10

28. How many times in the last 12 months did your child visit a doctor's office or clinic for urgent treatment of asthma symptoms? [URGENT VISIT = NOT SCHEDULED OR SCHEDULED < 24 HRS AHEAD OF TIME. DO NOT INCLUDE ED OR HOSPITAL VISITS]

_____ times or Never

F. ASTHMA AWARENESS OF PARENT

Please tell us if the following statements are true of false.

29. Most people with asthma can become free of symptoms with proper treatment

True 01
False 02

30. Asthma is characterized by inflammation of the airways, which if controlled can greatly reduce symptoms

True 01
False 02

31. If someone with asthma feels well, it is okay to stop taking his or her medications?

True 01
False 02

Parent Name_____

That's it! Do you have any questions or comments? As you know, we're going to call you in 2 weeks to see how [*child*] is doing.

What's the best number to reach you? ☐ Home(_____) _ _ _- _ _ _ _ ☐ Work (____)- _ _ _- _ _ __ _

Other (specify) (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

When is the best time to call: Between _____ and _____ AM PM

Is it okay to leave a message on the answering machine? YES NO

If you are not available when we call, is there another family member who we could talk to that is familiar enough with [child's] asthma care?

_____ (name)

_____ (relationship)

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