ASTHMA *GUIDELINES FOR CARE* FLOW SHEET

Patient Name:	**Physician Name:**
Date of Birth:	**Patient number:**

EVERY VISIT	**Date**	**Date**	**Date**	**Date**
Review Daily Action Plan, Symptoms and Peak Flow Diary				
Smoking Status (Y/N) If yes: cessation addressed?				
Frequency of Symptoms				
Activity Level				
Exacerbation Frequency (ER visit?)				
Peak Flow Rate LPM (Compare to Personal Best)				
Peak Flow, Spacer or Holding Chamber Technique				
Medication Adherence				
Medication Review (Do they have 30-day supply of reliever meds?)				
Goals of Therapy (Met/Not met)				
Trigger Control Plan				
MEDICATIONS	**Y/N/NA**	**Y/N/NA**	**Y/N/NA**	**Y/N/NA**
Short Acting Beta Agonist:				
Long Acting Beta Agonist:				
Anticholinergic:				
Inhaled Corticosteroid:				
Leukotriene Antagonist:				
Theophylline:				
Oral Corticosteroid:				
Osteoporosis Treatment:				
Antibiotic:				
Smoking Cessation Aids				
ANNUAL or AS INDICATED	**Results**	**Results**	**Results**	**Results**
Spirometry (FEV_1, FVC & % Predicted)				
Serum Theophylline Level				
Allergy Testing (all persistent)				
	Date	**Lot #**		
Flu Vaccine (Annual)				