ADULT ASTHMA PATIENT CARE FLOW SHEET
POST-DIAGNOSIS FOLLOW-UP VISITS #2 AND #3

Patient Name: _____	**Age** _____**Date of Diagnosis:** _____	**Influenza Vaccination** (this year)**:** ☐ Yes ☐ No ☐ Declined ☐ Past reaction/allergy Pneumococcal: ☐ which: _____ Covid ☐ TdaP ☐ Shingles ☐

	Measure since last visit	**Follow up VISIT # 2: Date 6wk-3 mos:** _____	**Follow up VISIT # 3: Date 3-6 mos:** _____
Assessment of Asthma Control	Reliever use ≥ 2 timese/week	☐ YES ☐ NO	☐ YES ☐ NO
	Daytime symptoms ≥ 2 days/week	☐ YES ☐ NO	☐ YES ☐ NO
	Night-time symptoms ≥ 1 time/week	☐ YES ☐ NO	☐ YES ☐ NO
	Limitations to physical activity	☐ YES ☐ NO	☐ YES ☐ NO
	Absence from work/school/social	☐ YES ☐ NO	☐ YES ☐ NO
	Attacks needing hospitalization/ER/ special visit/ prednisone	☐ YES ☐ NO	☐ YES ☐ NO
	FEV1 or PEF ≤ 90% of personal best	☐ YES ☐ NO	☐ YES ☐ NO
	Asthma worsenings** in the last week	☐ YES ☐ NO	☐ YES ☐ NO
	***Asthma worsening can be defined as an increase in asthma symptoms that are considered "bothersome", that affect normal functioning or sleep, or that lead to an increase in as-needed rescue medication*		
	If YES to any of the above, patient is at increased risk for an exacerbation. Assess reasons for poor control below. If in Control to all of the above, refer to section on Asthma Management Plan.		
Reasons for Poor Asthma Control	Smoking	☐ YES ☐ NO	☐ YES ☐ NO
	Other triggers (*consider occupational!)*	☐ YES ☐ NO	☐ YES ☐ NO
	Check inhaler technique	☐ YES ☐ NO	☐ YES ☐ NO
	Check drug adherence	☐ YES ☐ NO	☐ YES ☐ NO
	Drug side effects/concerns	☐ YES ☐ NO *If yes, list concerns:*_____	☐ YES ☐ NO *If yes, list concerns:*_____
	Drug or device coverage	☐ YES ☐ NO	☐ YES ☐ NO
	Understand chronic nature of asthma?	☐ YES ☐ NO	☐ YES ☐ NO
	Co-morbidities present	☐ Rhinitis ☐ GERD ☐ Sinusitis ☐ Obesity ☐ Nasal Polyps ☐ Other:	☐ Rhinitis ☐ GERD ☐ Sinusitis ☐ Obesity ☐ Nasal Polyps ☐ Other:
	Biomarker?	☐ BEC ☐ FENO ☐ sIgE	☐ BEC ☐ FENO ☐ sIgE
Asthma Management Plan	Inhaler technique reviewed	☐ YES ☐ NO	☐ YES ☐ NO
	Formal asthma education provided	☐ YES ☐ NO	☐ YES ☐ NO
	Patient goals for management	☐ Normal daily activities ☐ No limitations to physical activities ☐ Simple treatment regimen ☐ No symptoms ☐ No absence from work/school ☐ Other: _____	☐ Normal daily activities ☐ No limitations to physical activities ☐ Simple treatment regimen ☐ No symptoms ☐ No absence from work/school ☐ Other: _____
	Personalized action plan (PAP) created at first visit? If NO, PAP created at this visit? Eg *http://fpagc.com/tools-resources* Allergy testing recommended? Blood eosinophil count reviewed? Change in reliever to ICS/LABA?	☐ YES ☐ NO *If **YES**, was it used since last visit?* ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ N/A ☐ YES ☐ NO ☐ N/A ☐ YES ☐ NO ☐ N/A ☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO *If **YES**, was it used since last visit?* ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ N/A ☐ YES ☐ NO ☐ N/A ☐ YES ☐ NO ☐ N/A ☐ YES ☐ NO ☐ N/A
	Referral(s)	☐ Allergist ☐ Pediatrician ☐ CRE: Canadian Network for Respiratory Care *http://cnrchome.net* ☐ Respirologist ☐ Nurse ☐ Other: _____	☐ Allergist ☐ Pediatrician ☐ CRE: Canadian Network for Respiratory Care *http://cnrchome.net* ☐ Respirologist ☐ Nurse ☐ Other: _____
	Change Pharmacotherapy: Add new therapy:		
	Biologic		
	Immunotherapy SLIT or SCIT		
	OR	☐ No modifications made	☐ No modifications made
Follow-up	Follow-up visit scheduled in:	☐ 1-2 weeks ☐ 3-6 months ☐ < 1 month ☐ Only as needed ☐ 1-2 months ☐ Other: _____	☐ 1-2 weeks ☐ 3-6 months ☐ < 1 month ☐ Only as needed ☐ 1-2 months ☐ Other: _____