Asthma Care Map for Primary Care

Initial Assessment

☐ N/A

Date YYYY/MM/DD | Visit ☐ Scheduled ☐ Unscheduled

Referring health care provider | Healthcare Professional Role Type e.g respirologist

Provider identifier assigning authority e.g Regulatory body for physicians & surgeons | Provider Identifier Type e.g provider billing number

Reason for referral

- ☐ New Asthma Diagnosis
- ☐ Suspected Asthma
- ☐ Severe Asthma
- ☐ Suboptimal Asthma Control
- ☐ Other

Asthma and COPD overlap ☐ Yes ☐ No

Anthropometric Vitals ☐ N/A

Height cm | BMI

Weight kg

Demographics ☐ N/A

Client Name (please print)

Client Identifier Type e.g Jurisdictional Health Number | Client Identifier Assigning Authority e.g OHIP

Date of Birth YYYY/MM/DD | Self Reported Ethnic Group

Postal / Zip Code | Sex Assigned at Birth

Lived Gender ☐ Female gender ☐ Male gender ☐ Gender diverse

Highest level of education

☐ < High school ☐ High school ☐ Post secondary< Bachelor's degree ☐ Bachelor's degree ☐ Post secondary > Bachelor's degree

Living With ☐ Partner ☐ Caregiver ☐ Lives alone ☐ Other _____

Asthma Diagnosis ☐ N/A

☐ Unknown ☐ Confirmed YYYY/MM/DD Date Confirmed/Excluded (If uncertain indicate "unknown" in the provided field) ☐ Spirometry or PEF attached

☐ Suspected ☐ Excluded # Age asthma was confirmed

Method used to confirm Asthma Diagnosis

(for individuals 6 years and older and younger individuals able to do spirometry)

	Pulmonary Function Measurement	Children (6 years and older)	Adult
	PREFERRED: Spirometry showing reversible airway obstruction		
☐	Reduced FEV_1/FVC **AND** Increased in FEV_1 after a bronchodilator or after course of controller therapy	Less than lower limit of normal* (<0.8-0.9)** **AND** ≥12%	Less than lower limit of normal* (<0.75-0.8)** **AND** ≥12% (and a minimum > 200ml)
	ALTERNATIVE: Peak Expiratory Flow (PEF) variabilty		
☐	Increase after a bronchodilator or after course of controller therapy **OR** Diurnal variation	≥20% **OR** Not recommended	60 L/min (minimum ≥20%) **OR** >8% based upon twice daily readings; >20% based upon multiple daily readings
	ALTERNATIVE: Positive Challenge Test		
☐	a) Methacholine Challange **OR** b) Exercise Challenge	PC_{20} <4 mg/mL (4-16 mg/mL is borderline; >16 mg/mL is negative) **OR** ≥10-15% decrease in FEV_1 post-exercise	

* Based on age, sex, height and ethnicity. ** Approximate lower limits of normal ratios for children and adults.

This information was orginally published in CAN Respir J2012;19(2);127-164

Method used to confirm Asthma Diagnosis

(for individuals 1-5 years of age NOT able to do spirometry)

☐ Recurrent Asthma Like Symptoms of Excerbation

AND Documentation of airflow obstruction

- ☐ Preferred: Documented wheezing or other signs of airflow observed by a health care provider
- ☐ Alternative: Convincing parental report of wheezing or other symptoms

AND Documentation of reversibility of airflow obstruction

- ☐ Preferred: Response to bronchodilator within 30min confirmed by a health care provider
- ☐ Alternative 1: Gradual but clear response to an anti-inflammatory therapy: after ≥ 4 hours of oral cortical steroids (OCS), within 3 months of moderate dose inhaled cortical steroids (ICS), expect decreased symptoms and exacerbation frequency and severity.
- ☐ Alternative 2: Response to bronchodilator within 30 min by parental history

AND No clinical evidence of an alternative diagnosis

This information was orginally published in CAN Resp J2015;22(3);135-143

Medications ☐ N/A

Respiratory Medications	Drug Name	Strength	Unit of Measure	Dose	Route	Rx Date	Adherence issues known or suspected? Y/N
Reliever							
Inhaled Corticosteriod (ICS)							
ICS/LABA combination							
Long Acting Beta-Agonists (LABA)*							
Leukotriene receptor antagonist (LTRA)							
Reliever/Controller							
Prednisone							
Biologics							
Nicotine product							
Medications prescribed at this visit							
Long acting muscarinic antagonists (LAMA)							
Other							

* Should not be used as a standalone

	Yes	No
Patient has a spacing device	☐	☐
Does at least one prescribed medication allow for a spacing device to be used?	☐	☐
Unfilled prescriptions. In the last 6 months has the patient been prescribed any asthma medications he/she has not obtained.	☐	☐

Past Medications

Yellow Zone Medications

Client Name _____ Jurisdictional Health Number _____

Family History of Lung Disease ☐ N/A

Family History of Asthma, Allergy and/or COPD ☐ Yes ☐ No ☐ Unknown

(If yes select allergic conditions from a list and indicate which relative)

Asthma	☐ Parent	☐ Sibling	☐ Both	☐ None	☐ Unknown
Allergy	☐ Parent	☐ Sibling	☐ Both	☐ None	☐ Unknown
Allergy drug	☐ Parent	☐ Sibling	☐ Both	☐ None	☐ Unknown
Allergy food	☐ Parent	☐ Sibling	☐ Both	☐ None	☐ Unknown
Eczema	☐ Parent	☐ Sibling	☐ Both	☐ None	☐ Unknown
Environmental allergies	☐ Parent	☐ Sibling	☐ Both	☐ None	☐ Unknown

Smoking ☐ N/A

Smoking Status ☐ Non-Smoker ☐ Ex-Smoker ☐ Current Smoker

Quit Date YYYY/MM/DD

Quit Duration

When was the last time you smoked a cigarette, even a puff?

☐ > 6 months ☐ 1-6 months ☐ < 1 month

Pack Years

Cig Smoked/day _____ / 20 X Years smoked _____ = Pack years _____

Passive Smoking Risk ☐ Yes ☐ No

Other

☐ e-cigarette/vaping ☐ Cannabis use ☐ Use of other tobacco

☐ Inhalation vapor use ☐ Other inhaled substances

Stages of Change Addressed

☐ pre-contemplation ☐ contemplation

☐ preparation ☐ action ☐ maintenance

Smoking Cessation Addressed

☐ Ask ☐ Advise ☐ Arrange

Smoking Cessation Quit Intentions

Are you planning to quit smoking?

☐ within a month ☐ within 6 months

☐ beyond 6 months ☐ not planning to quit

Asthma Severity ☐ N/A

Visit(s) to family physician in the last 12 months for asthma symptoms

If Yes, indicate the number of primary care visits for asthma in the last 12 months

Routine primary care visits _____ Urgent primary care visits _____

Visit(s) to a specialist for asthma

	Yes	No	Unknown	Last 12 Months
Respirologist	☐	☐	☐	☐
General Internist	☐	☐	☐	☐
Allergist	☐	☐	☐	☐
Pediatrician	☐	☐	☐	☐

	Yes	No	Unknown	Recent < 1yr	Total # ever
ED visits ever for asthma	☐	☐	☐	☐	
Hospitalized ever for asthma	☐	☐	☐	☐	
Near fatal asthma episode (coma/intubated/icu/CO2)	☐	☐	☐	☐	
Recent best FEV_1 or PEF < 60% predicted #	☐	☐	☐		
ICU admissions in the last 12 months	☐	☐	☐	# ICU admissions	# intubations
Systemic steroid use ever	☐	☐	☐	Date last used	Total # ever

Risk Factors for Exacerbations ☐ N/A

Risk Factors ☐ Yes ☐ No (If yes select from a list below)

Exposure to Second-Hand Smoke ☐ Yes ☐ No ☐ Unknown

History of Previous Severe Exacerbation (requiring either systemic steroids, ED visit or hospitalization ☐ Yes ☐ No ☐ Unknown

Poorly controlled asthma as per CTS criteria ☐ Yes ☐ No ☐ Unknown

Current smoker ☐ Yes ☐ No ☐ Unknown

SABA Overuse ☐ < 1 cannister/month ☐ > 2 cannisters/month ☐ 1-2 cannisters/month

Current Symptoms ☐ N/A

	Yes	No
Breathlessness	☐	☐
Chest tightness	☐	☐
Wheeze	☐	☐
Cough	☐	☐
Sputum	☐	☐
Frequent colds	☐	☐
If yes frequency ☐ 0-3/year ☐ 4-7/year ☐ ≥8/year		
Colds that last longer than 7 days	☐	☐
Symptoms worse at morning (including cough)	☐	☐
Symptoms worse at night (including cough)	☐	☐
Chest pain	☐	☐

Barriers ☐ N/A

Barriers ☐ Yes ☐ No (If yes select from the list below)

	Yes	No
Adherence	☐	☐
Cultural issue	☐	☐
Effect of substances abuse	☐	☐
Financial issue	☐	☐
Lack of private drug plan	☐	☐
Language	☐	☐
Literacy	☐	☐
Medication side effects	☐	☐
Pregnancy	☐	☐
Social/Family issues	☐	☐
Other _____	☐	☐

Breath Sounds ☐ N/A

☐ Normal ☐ Abnormal

If abnormal, select auscultory finding

☐ Wheezes ☐ Crackles ☐ Reduced

☐ Bronchial (harsh and prolonged inspiration and expiration)

Additional Notes

Client Name _____ Jurisdictional Health Number _____

Allergy History ☐ N/A

Allergic Condition ☐ Yes ☐ No ☐ Unknown

If yes, select from the list of possible allergic conditions (Self/Parent report)

	Yes	No	Unknown
Anaphylaxis	☐	☐	☐
Bronchospasm	☐	☐	☐
Conjunctivitis	☐	☐	☐
Eczema	☐	☐	☐
Rhinitis	☐	☐	☐

Allergic Skin Prick Test

☐ Negative ☐ Positive ☐ Not done ☐ Self/Parent-report

Date DD / MM / YYYY

If positive identify positive response to possible allergens listed

	Yes	No
Cat	☐	☐
Cockroaches	☐	☐
Dog	☐	☐
Dust/Dust mites	☐	☐
Feathers	☐	☐
Fungi/Mould	☐	☐
Grasses	☐	☐
Pollen	☐	☐
Ragweed	☐	☐
Trees	☐	☐
Occupational sensitizers	☐	☐

Other pets _____

Other _____

Occupational History ☐ N/A

Current Employment Status: Check all the apply.
Note - This includes self-employment and working from home:

☐ Full-Time ☐ Part-Time ☐ Shift work ☐ Retired

☐ Modified duties ☐ Off work due to respiratory health

☐ Other _____

Current Employment_____

Did your Asthma symptoms start at work? ☐ Yes ☐ No

Do/ did your Asthma symptoms worsen at work? ☐ Yes ☐ No

If the response options are YES consider completing the WRASQ(L) questionnaire

Complete WRASQ(L)© today? ☐ Yes ☐ No

Triggers and Exposures ☐ N/A

Category If yes select patient reported triggers & exposures from list.	Triggers ☐ Yes ☐ No ☐ Unknown			Exposures ☐ Yes ☐ No ☐ Unknown		
	Yes	No	Unknown	Yes	No	Unknown
Birds	☐	☐	☐	☐	☐	☐
Cats	☐	☐	☐	☐	☐	☐
Chemicals	☐	☐	☐	☐	☐	☐
Cockroaches	☐	☐	☐	☐	☐	☐
Cold air	☐	☐	☐	☐	☐	☐
Dogs	☐	☐	☐	☐	☐	☐
Dust/Dust mites	☐	☐	☐	☐	☐	☐
Emotion/Stress	☐	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐	☐
Feather bedding/Pillows	☐	☐	☐	☐	☐	☐
Fireplace/Woodstove	☐	☐	☐	☐	☐	☐
Food allergy nut	☐	☐	☐	☐	☐	☐
Food allergy seafood	☐	☐	☐	☐	☐	☐
Fumes	☐	☐	☐	☐	☐	☐
Fungi/Mould	☐	☐	☐	☐	☐	☐
Gas stove	☐	☐	☐	☐	☐	☐
Grasses	☐	☐	☐	☐	☐	☐
High humidity	☐	☐	☐	☐	☐	☐
Medications	☐	☐	☐	☐	☐	☐
Outdoor pollution	☐	☐	☐	☐	☐	☐
Perfume/Air fresheners	☐	☐	☐	☐	☐	☐
Pollen	☐	☐	☐	☐	☐	☐
Ragweed	☐	☐	☐	☐	☐	☐
Respiratory Infections	☐	☐	☐	☐	☐	☐
Second hand smoke	☐	☐	☐	☐	☐	☐
Trees	☐	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐	☐

Environmental Controls ☐ N/A

Environmental Control Measures in Place ☐ Yes ☐ No (If Yes, Select patient-reported, control measures in place. Optional: repeat questions for individuals with a secondary home.)

	Yes	No	Suggested
Air conditioning in summer	☐	☐	☐
Central or hepa-filter vacuum	☐	☐	☐
Dehumidifier (desired target < 50%)	☐	☐	☐
Dust mite mattress cover	☐	☐	☐
Dust mite pillow cover	☐	☐	☐
Removed carpets	☐	☐	☐
Heat exchanger	☐	☐	☐
Heating gas/Oil	☐	☐	☐
Heating electric/Radiator	☐	☐	☐
Alternative to wood heat (fireplaces, wood stoves, furnaces) or mitigation strategies	☐	☐	☐

	Yes	No	Suggested
Humidifier in winter (desired target < 50%)	☐	☐	☐
Humidifier all year round (desired target < 50%)	☐	☐	☐
Non-feather blanket	☐	☐	☐
Pets kept out of bedrooms	☐	☐	☐
Regular furnace filter change	☐	☐	☐
Remove pets from home	☐	☐	☐
Wash linens in hot water	☐	☐	☐
Wash pets once a week	☐	☐	☐
Wear mask or respirator as needed	☐	☐	☐
Other _____	☐	☐	☐

Client Name _____ Jurisdictional Health Number _____

Comorbidities ☐ N/A

Comorbid Conditions ☐ Yes ☐ No (If yes select relevant asthma comorbid diagnosis from a list)

	Yes	No	Unknown
A-1 Antitrypsin deficiency	☐	☐	☐
Adenoid hypertrophy	☐	☐	☐
Allergic bronchoplumonary aspergillosis	☐	☐	☐
Allergic rhinoconjunctivitis	☐	☐	☐
Anaphylaxis	☐	☐	☐
ASA sensitivity	☐	☐	☐
Cancer	☐	☐	☐
COPD	☐	☐	☐
Cor Pulmonale/ heart failure	☐	☐	☐
Cerebrovascular accident (CVA)	☐	☐	☐
Eczema/ Hives/ Urticaria	☐	☐	☐
Eosinophilia	☐	☐	☐
Eosinophilic granulomatosis with polyangiitis (EGPA) (Churg-Strauss Syndrome)	☐	☐	☐
Gastroesophageal reflux disease (GERD)	☐	☐	☐
Glaucoma/Cataracts	☐	☐	☐
Immune deficiency	☐	☐	☐
Dysfunctional breathing (Laryngeal Dysfunction and/or Hyperventilation Syndrome)	☐	☐	☐
MI	☐	☐	☐
Osteopenia/ Osteoporosis	☐	☐	☐
Panic disorders	☐	☐	☐
Respiratory failure	☐	☐	☐
Rhinitis/ Nasal polyposis/ Sinusitis	☐	☐	☐
Sleep apnea	☐	☐	☐
Swallowing dysfunction/Dysphagia	☐	☐	☐
Other cardiovascular disease	☐	☐	☐
Other	☐	☐	☐

Asthma Control ☐ N/A

(Note time interval for capturing asthma control data is the last four weeks)

Daytime Symptoms (Average number of day/week in the last 4 weeks with dyspnea, cough, wheeze and/or chest tightness)	# of Days/Week (control is ≤ 2 days/week)	
Nighttime Symptoms (Average number of night/weeks in the last 4 weeks with dyspnea, cough, wheeze and/or chest tightness)	# of Nights/Week (Control=<1)	
Physical activity limited (Due to asthma in the last 4 weeks)	☐ Yes ☐ No	
Exacerbations since last visit (Hospital admission, ED visit, Walk-in-Clinic)	☐ Yes ☐ No	# of Exacerbations
Dates of Exacerbations (Hospital admission, ED visit, Walk-in-Clinic)	YYYY/MM/DD	YYYY/MM/DD
School/Work/Social activity absences due to asthma (Average number of days/week in the last 4 weeks)	☐ Yes ☐ No	# of Days/Week
Needs Reliever (Average number of day/week in the last 4 weeks)	# of Doses/Week (control is ≤ 2)	
Sputum Eosinophils (Measured Yes/No: if yes, %)	☐ Yes ☐ No	% (Control=<2-3%)
FEV_1 or PEF ≥90% predicted or personal best	☐ Yes ☐ No	
PEF diurnal variation <15% over a 2 week period	☐ Yes ☐ No	
Asthma Controlled	☐ Yes ☐ No	

Based on control criteria from the 2021 CTS Guideline - a focused update on the management of very mild and mild asthma
Any ONE element NOT in control- OVERALL NOT in control.

Pulmonary Function Test ☐ N/A

Spirometry	LLN	PRE		POST	
	Actual	Actual	% Pred	Actual	% Pred
FEV_1	L/Min	L/Min	%	L/Min	%
FVC	L/Min	L/Min	%	L/Min	%
PEF	L/Min	L/Min	%	L/Min	%
FEV_1 / FVC					

Peak Flow Meter	Actual
Predicted PEF	L/Min
Personal Best PEF	L/Min
Actual PEF	L/Min
PEF % pred	% pred
PEF % Personal Best	% PB

Methacholine	Actual
PC_{20} or PD_{20}	mg/mL or mcg

Additional Notes

Asthma Action Plan ☐ N/A

	Yes	No	
Written asthma action plan provided	☐	☐	YYYY/MM/DD
Written asthma action plan revised	☐	☐	YYYY/MM/DD
Asthma action plan reviewed & not changed	☐	☐	YYYY/MM/DD
Yellow or red zone of action plan followed, since last vist	☐	☐	# of Times

Asthma Control Zone ☐ N/A

(Provider assessment based upon prior Asthma Control parameter responses)

If Asthma controlled option answer is Green ☐ Green

If Asthma uncontrolled option is yellow or red ☐ Yellow ☐ Red

Client Name | Jurisdictional Health Number

Immunizations ☐ N/A

	Yes	No	Unknown
Immunizations discussed	☐	☐	☐
Influenza vaccination received	☐	☐	☐

Date of last influenza vaccination: YYYY/MM/DD

Investigations ☐ N/A

Chest CT
Date of last: YYYY/MM/DD Results:

Bone Mineral Density Test (BMD Test)
Date of last: YYYY/MM/DD Results: g/cm²

IgE
Date of last: YYYY/MM/DD Results: lu/ml

Blood Eosinophil Levels
10*3 /uL

Education Interventions ☐ N/A

Education provided at this visit ☐ Yes ☐ No
(User will be asked to identify education provided at this visit by selecting items from a list)

	Yes	No
Adherence to medications	☐	☐
Barriers addressed	☐	☐
Coping strategies addressed	☐	☐
Definition of asthma	☐	☐
Device technique optimal	☐	☐
Early recognition & treatment of exacerbations	☐	☐
Environmental tobacco smoke exposure	☐	☐
Epinephrine auto injector	☐	☐
Exercise	☐	☐
Immunotherapy	☐	☐
Inhaler technique	☐	☐
Medications	☐	☐
Provide patient education materials	☐	☐
Self management goal	☐	☐
Smoking cessation	☐	☐
Triggers & environmental controls	☐	☐
Other	☐	☐

Patient understanding of education/Information provided at this visit: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Referrals ☐ N/A

	Yes	No	Suggested
Allergist	☐	☐	☐
Asthma Education Program/ CRE	☐	☐	☐
Respirologist	☐	☐	☐
Smoking Cessation Program	☐	☐	☐
Pediatrician	☐	☐	☐
Internal Medicine Specialist	☐	☐	☐
ENT physician	☐	☐	☐
Occupational Medication Specialist	☐	☐	☐
Speech Therapist	☐	☐	☐
Gastroenterologist	☐	☐	☐
Other specialist	☐	☐	☐

Assessment Tools ☐ N/A

	Yes	No
Quality of Life assessment completed	☐	☐
Mini Asthma Quality of Life questionnaire score	#	

Follow-up Visit Scheduled in (time frame from current visit) ☐ N/A

☐ 1 Week ☐ 1 Month ☐ 4-6 Months
☐ 2 Weeks ☐ 2 Months ☐ 6-12 Months
☐ 3 Weeks ☐ 3 Months ☐ "Wait and see"

Other

Additional Notes / Plan