Asthma Care Map for Primary Care
Follow -Up Assessment

☐ N/A

Date YYYY/MM/DD

Asthma and COPD overlap ☐ Yes ☐ No

Visit Type ☐ Scheduled ☐ Unscheduled ☐ Telephone f/u ☐ Urgent (Acutely Ill)

Demographics ☐ N/A

Client Name (please print)

Date of Birth YYYY/MM/DD

Client Identifier Type e.g Jurisdictional Health Number

Client Identifier Assigning Authority e.g OHIP

Anthropometric Vitals ☐ N/A

Height cm Weight kg BMI

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)

- ☐ spirometry showing reversible airflow obstruction
- ☐ PEF variability
- ☐ MCT or exercise challenge

Method used to confirm Asthma Diagnosis
(for individuals 1-5 years of age NOT able to do spirometry)

- ☐ documented airflow obstruction
- ☐ documented reversibility of airflow obstruction
- ☐ no clinical evidence of an alternative diagnosis

Medications ☐ N/A

Respiratory Medications	Drug Name	Strength	Unit of Measure	Dose	Route	Rx Date	Adherence issues known or suspected
Reliever							Yes ☐ No ☐
Inhaled Corticosteriod (ICS)							Yes ☐ No ☐
ICS/LABA combination							Yes ☐ No ☐
Long Acting Beta-Agonists (LABA)*							Yes ☐ No ☐
Leukotriene receptor antagonist (LTRA)							Yes ☐ No ☐
Reliever/Controller							Yes ☐ No ☐
Prednisone							Yes ☐ No ☐
Biologics							Yes ☐ No ☐
Nicotine product							Yes ☐ No ☐
Medications prescribed at this visit							Yes ☐ No ☐
Long acting muscarinic antagonists (LAMA)							Yes ☐ No ☐
Other							Yes ☐ No ☐

* 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

Risk Factors for Exacerbations ☐ N/A

Risk factors changed since last visit? ☐ Yes ☐ No

If yes, please specify:

Smoking ☐ N/A

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

Passive Smoking Risk ☐ Yes ☐ No

Quit Date YYYY/MM/DD

Other ☐ e-cigarette/vaping ☐ Cannabis use ☐ Use of other tobacco ☐ Inhalation vapor use ☐ Other inhaled substances

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 ____

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

Client Name _____ Jurisdictional Health Number _____

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	< 1 year
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 steriod use ever	☐	☐	☐	Date last used	Total # ever

Triggers and Exposures ☐ Unchanged from last visit ☐ 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 ____	☐	☐	☐	☐	☐	☐

Typical Symptoms ☐ N/A

Any new symptoms since last visit (e.g., chest pain)?

☐ Yes ☐ No If yes, please specify: ____

Breath Sounds ☐ N/A

☐ Normal ☐ Abnormal

If abnormal, select auscultory finding

☐ Wheezes ☐ Crackles ☐ Reduced

☐ Bronchial (harsh and prolonged inspiration and expiration)

Additional Notes ____

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

☐ Unchanged from last visit

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

Client Name _____ Jurisdictional Health Number _____

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 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 _____	☐	☐	☐

Comorbidities ☐ N/A

Comorbid Conditions ☐ Yes ☐ No ☐ Unchanged from last visit

(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

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	LNN	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

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

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

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