CLIENT INTAKE AND ASTHMA SCREENING

FOR AGENCY USE ONLY		
Client ID No.	**Case ID No.**	**Date Completed**
Organization	**Educator Name**	**Email**

REFERRAL INFORMATION

Referral Date

Referral Organization Name

Referral Type

- ☐ Physician/healthcare provider
- ☐ School/school nurse
- ☐ Friend/family
- ☐ Federally Qualified Health Center
- ☐ Local and Tribal Health Department
- ☐ Community-based organization
- ☐ Self-referral
- ☐ Hospital/emergency department
- ☐ Health plan
- ☐ Other:

CLIENT AND GUARDIAN CONTACT INFORMATION

Name – Client (First, MI, Last)

Date of Birth (mm/dd/yy)

Name – Parent/Guardian (if client is under 18)

Relationship

- ☐ Mother
- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Aunt
- ☐ Uncle
- ☐ Custodian
- ☐ Legal Guardian

Street Address, City, Zip Code

Rent/own?

- ☐ Rent
- ☐ Own
- ☐ Other:

Property Type

- ☐ Single-family
- ☐ Multi-family

Home Phone

Cell Phone

Email Address

Preferred Contact Method

ALTERNATE CONTACT INFORMATION

Name – Alternate Contact	**Phone Number**	**Email Address**

Street Address, City, Zip Code

HEALTH INSURANCE/PCP INFORMATION

Is client enrolled in Medicaid?
☐ Yes ☐ No ☐ Unsure

Does client have a Primary Care Provider (PCP)?
☐ Yes ☐ No

If YES, what is PCP's name?	**If YES, PCP healthcare system?**	**If NO, was client referred to PCP?**

CLIENT DEMOGRAPHICS

Gender

- ☐ Woman/Girl
- ☐ Man/Boy
- ☐ Nonbinary
- ☐ Transgender
- ☐ Unknown
- ☐ Other:

Is the client eligible due to pregnancy?
☐ Yes ☐ No

Ethnicity

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

Race

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ White
- ☐ Native Hawaiian/ Pacific Islander
- ☐ Unknown
- ☐ Other:

Primary Language Spoken
☐ English ☐ Spanish ☐ Unknown ☐ Other:

ASTHMA CONTROL ASSESSMENT

Write the number of each answer in the score box. Add the numbers from each box for a total score.

1. In the past 4 weeks, how much of the time did your (*your child's*) asthma keep you (*them*) from getting as much done at work, school or home? **SCORE**

All of the time [1] | Most of the time [2] | Some of the time [3] | A little of the time [4] | None of the time [5] | ☐

2. During the past 4 weeks, how often have you (*your child*) had shortness of breath?

More than once a day [1] | Once a day [2] | 3 to 6 times a week [3] | Once or twice a week [4] | Not at all [5] | ☐

3. During the past 4 weeks, how often did your (*your child's*) asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you (*your child*) up at night or earlier than usual in the morning?

4 or more nights a week [1] | 2 or 3 nights a week [2] | Once a week [3] | Once or twice [4] | Not at all [5] | ☐

4. During the past 4 weeks, how often have you (*your child*) used your (*their*) rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times per day [1] | 1 to 2 times per day [2] | 2 or 3 times a week [3] | Once a week or less [4] | Not at all [5] | ☐

5. How would you rate your (*your child's*) asthma control during the past 4 weeks?

Not controlled at all [1] | Poorly controlled [2] | Somewhat controlled [3] | Well controlled [4] | Completely controlled [5] | ☐

Asthma Control Assessment Total Score ☐

ADDITIONAL ASTHMA SCREENING

Have you (*your child*) had an emergency department visit for asthma in the last year?
☐ Yes ☐ No

Have you (*your child*) had a hospitalization for asthma in the last year?
☐ Yes ☐ No

Has your child's school called 911 for their asthma in the last year? (for clients 18 years or under only)
☐ Yes ☐ No

Was your child referred to this program by a school nurse due to missed school days, office visits, incorrect medication use, etc.? (for clients 18 years or under only)
☐ Yes ☐ No

Were you (*your child*) referred to this program by a health care provider due to office visits, incorrect medication use, etc.?
☐ Yes ☐ No

ASTHMA SCREENING RESULTS

If the Asthma Control Assessment total score is less than or equal to 19 or the client answered Yes to any of the additional asthma screening questions above, the client meets the asthma control eligibility requirements for the Asthma-Safe Homes Program.

Does the client qualify for the program?
☐ Yes ☐ No

If yes, does the client agree to enroll in the program?
☐ Yes; date enrolled: ☐ No