

A. Administrative Data (required for case validation)

Encounter #: _____

The encounter number is the CDB number, not the medical record number. This number should be unique to this patient's stay at your institution.

2. Hospital admission date and time:

Date ___/___/___ (mm/dd/yyyy) Time ____:____ (military time)

3. Hospital discharge date and time:

Date ___/___/___ (mm/dd/yyyy) Time ____:____ (military time)

4. Date of birth: ___/___/___ (mm/dd/yyyy)

B. Demographics

1. Gender: (check one)

Female Male

2. Primary payer: (check one)

- None (uninsured)
- Managed Care: HMO/Medicare Managed Care/Medicaid Managed Care
- Medicaid
- Medicare
- Preferred Provider
- Private/Indemnity/Commercial
- Unknown
- Other (specify) _____

3. Race: (check one)

- African American
- Asian
- Caucasian
- Hispanic
- Native American
- Other (specify) _____

4. Lifestyle: (check one)

- Lives alone
- Lives with spouse/family
- Lives with other (not spouse/family)
- Long-term care/SNF
- Homeless
- Unknown
- Other (specify) _____

C. Presentation

1. Location of first assessment prior to admission: (check one)

- Transfer
- ED
- Clinic/Office
- Home
- Not recorded*/not available

C. Presentation (cont.)

2. First Peak Expiratory Flow Rate (PEFR) prior to admission:

2a. Findings: PEFR _____ L/min
Date: ___/___/___ (mm/dd/yyyy) Time _____ : _____ (military time)

2b. Timing of this PEFR measurement:

- Pre- bronchodilation
- Post- bronchodilation
- Not recorded

*Note: if only one PEFR documented and PEFR obtained more than 60 minutes after presentation, list as final PEFR; and list initial PEFR as "not recorded"

3. Last Peak Expiratory Flow Rate (PEFR) prior to admission:

3a. Findings: PEFR _____ L/min
Date: ___/___/___ (mm/dd/yyyy) Time _____ : _____ (military time)

3b. Timing of this PEFR measurement:

- Pre- bronchodilation
- Post- bronchodilation
- Not recorded

4. First assessment of vital signs prior to admission:

4a. Respiratory rate per minute: _____

4b. Pulse oximetry:

- SaO₂: _____ %
- Oxygen
- Room air

4c. Arterial blood gas:

- PO₂: _____ mmHg
- Oxygen
- Room air

5. First respiratory assessment for pediatric patients:

- Wheezing
 - On expiration
 - Inspiration and expiration
 - Silent Chest
 - Not recorded

Inspiratory/expiratory ratio

- 2:1
- 1:1
- 1:2
- 1:3
- Not recorded

Accessory muscle use

- None
- +
- ++
- +++
- Not recorded

6. First systemic steroids administered:

Yes (if Yes, answer 7a. and 7b.) No Not recorded

6a. Date and time of first dose: Date: ___/___/___ (mm/dd/yyyy) Time _____ : _____ (military time)

- 6b. PO
- IV
- Unknown

C. Presentation (cont.)

Inpatient admission (this admission location): (check one)

- Critical care unit
- Step down unit
- Medical/Surgical unit
- Other (specify) _____

D. Medical History

1. Identify the patients asthma physician prior to admission: (check one)

- None
- Allergist
- Internist/Family practitioner
- Pediatrician
- Pulmonologist
- Unable to determine from the medical record
- Other _____

2. Has the patient been previously hospitalized for asthma:

- Yes (if Yes, answer 2a.) No Not recorded

2a. How recently was the patient hospitalized;

- < 1 week
- ≤ 1 month
- > 1 month - < 1 year
- ≥ 1 year
- Not recorded

Previous hospitalization defined as an overnight hospitalization, not related to this admission.

Did patient have an asthma action plan prior to admission:

- Yes
- No
- Not recorded

An asthma action plan is defined as a written plan given to the patient by a doctor or nurse for treating asthma. A plan may indicate a peak flow measurement or describe symptoms that require the patient to increase their asthma medication.

4. Does the patient use a nebulizer at home: Yes No Not recorded

5. Smoking: (check all that apply)

- Never smoked
- Current smoker
- Ex smoker
- Exposure to passive smoke in the home
- Not recorded

6. Adult cases co-morbid and present condition(s): (check all that apply)

History of	Present Condition
<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Congestive heart failure (CHF)
<input type="checkbox"/>	<input type="checkbox"/> Chronic obstructive pulmonary disease
<input type="checkbox"/>	<input type="checkbox"/> Gastroesophageal reflux disease (GERD)
<input type="checkbox"/>	<input type="checkbox"/> Illicit inhalational drug use (e.g. crack, heroin)
<input type="checkbox"/>	<input type="checkbox"/> Obesity
<input type="checkbox"/>	<input type="checkbox"/> Pneumonia
<input type="checkbox"/>	<input type="checkbox"/> Psychiatric disorder (e.g. schizophrenia)
<input type="checkbox"/>	<input type="checkbox"/> Sinusitis
<input type="checkbox"/>	<input type="checkbox"/> Other chronic lung disease: (specify) _____

D. Medical History (cont.)

7. Pediatric cases co-morbid and present condition(s): (check all that apply)

History of	Present Condition	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Bronchiolitis
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/eczema
<input type="checkbox"/>	<input type="checkbox"/>	GERD
<input type="checkbox"/>	<input type="checkbox"/>	Obesity
<input type="checkbox"/>	<input type="checkbox"/>	Otitis media
<input type="checkbox"/>	<input type="checkbox"/>	Prematurity
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory syncytial virus (RSV)
<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis

E. Laboratory Testing, Diagnostics, and Medication

1. Record the highest and the lowest PEFR achieved per day. Also record number of PEFRs per 24 hours:

	1 st 24 hours	2 nd 24 hours	3 rd 24 hours	Last prior to D/C
Highest PEFR L/min	_____	_____	_____	_____
Lowest PEFR L/min	_____	_____	_____	_____
Number of PEFRs Recorded per day	_____	_____	_____	_____

Note: if only one PEFR recorded per day, enter the value as the highest PEFR for that day.

Check all that apply

2. Medication: (check all that apply)	Taken within 4 weeks prior to admission	Prior to Admission (ED, office, etc.)	1 st 24 hours of admission	2 nd 24 hours of admission	3 rd 24 hours of admission	Discharge (for home use)
Short acting b-agonist						
Long acting b-agonist						
Systemic steroids						
Inhaled corticosteroids						
Magnesium						
Methylxanthines						
Cromolyn						
Nedocromil						
Anticholinergic						
Leukotriene modifier						
Antibiotics						

3. Provide number of tests performed during admission: (check all that apply and indicate number)

Test	Total number during admission
<input type="checkbox"/> ABG	_____
<input type="checkbox"/> Blood cultures	_____
<input type="checkbox"/> CBC	_____
<input type="checkbox"/> Chest x-ray	_____
<input type="checkbox"/> Electrolytes	_____
<input type="checkbox"/> Sputum c/s or Gram's stain	_____
<input type="checkbox"/> Sweat chloride (pediatric only)	_____

E. Laboratory Testing, Diagnostics, and Medication (cont.)

Was a formal pulmonary function testing, (e.g. FEV¹) ordered at least once during stay:
 Yes No Not recorded

F. Complications

1. Inpatient complications: (check all that apply, and include relevant dates)

- Intubation _____/_____/_____ (mm/dd/yyyy)
- Extubation _____/_____/_____ (mm/dd/yyyy)
- Readmission to ICU _____/_____/_____ (mm/dd/yyyy)
- Death _____/_____/_____ (mm/dd/yyyy)

G. Key Discharge Factors

1. Is there documentation in the chart of asthma education? Yes No Unknown

2. Smoking cessation: (check one)

- Active smoker: smoking cessation program documented
- Active smoker: smoking cessation program not documented
- Does not smoke
- Smoking status not recorded

3. Was patient or primary caregiver instructed to see a physician after discharge?

- Yes (if Yes, answer 3a.) No Not recorded

3a. How soon was patient to see the physician: (check one)

- 1 - 2 days
- 3 - 7 days
- 8 - 14 days
- 15 - 28 days
- > 28 days
- Other interval _____
- Duration not documented

4. Was the follow-up appointment made with the physician before patient was discharged:

- Yes No Not known

5. Did the patient receive an asthma action plan? Yes (if Yes, answer 5a.) No Unknown

5a. Which of the following describe the asthma action plan the patient received:

- Individualized asthma action plan
- General information/Brochure(s)
- Video
- Audio tape
- Not recorded

6. Was peak flow meter ordered for patient use post discharge?

- Yes (if Yes, answer 6a.) No Unknown

6a. Did patient receive it before leaving the hospital? Yes No Unknown

7. Was MDI ordered for patient use post discharge? Yes (if Yes, answer 7a. and 7b.) No Unknown

7a. Was spacer device ordered? Yes (if Yes, answer 8b.) No Unknown

7b. Did patient receive the MDI before leaving the hospital: Yes No Unknown

8. Was home nebulizer ordered for patient use post discharge:

- Yes No Unknown