**Asthma Healthcare Plan**

| **Name:** | FirstName LastName | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- |
| **These are my medical diagnoses related to respiratory conditions:** | List all diagnoses or conditions related to respiratory conditions, including those likely to exacerbate asthma. |
| **I am allergic or sensitive to these things:** | List all known allergies and sensitivities |
| **The goal of this Healthcare Plan is:** | [ ]  I will be free of exacerbation of my asthma (asthma attack) for the duration of the ISP year.[ ]  I will take my medications as prescribed and follow doctor’s orders for the duration of the ISP year.[ ]  I will successfully practice relaxation techniques to help decrease the impact and shorten the duration of an asthma attack.[ ]  Describe any other goal for management of my asthma here.  |
| **Progress in the past year:** | Describe the status of my health for the past year related to asthma and respiratory conditions. |
| **In an EMERGENCY****Call 911 IMMEDIATELY if I:****🡪 Experience an asthma attack (severe shortness of breath or wheezing) that cannot be managed with my rescue inhaler;****🡪 Have a fall with injury, or hit my head during an asthma attack.****🡪 Lose consciousness (become unresponsive).****🡪 Describe any additional instructions here.** |
| **DO NOTMAKE NOTIFICATIONS PHONE CALLS UNTIL****I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** |
| **As of the date of this plan, the average frequency of my asthma attacks is:** | [ ]  Several times a week[ ]  Several times a month[ ]  Less than monthly[ ]  It has been over a year since my last asthma attack |
| **These are the things that increase my risk of asthma and asthma attacks:** | [ ]  I have allergies to things in my environment.[ ]  I have gastroesophageal reflux disease (GERD).[ ]  I frequently have upper respiratory infections and/or sinusitis.[ ]  I have a chronic condition that affects my breathing, such as COPD.[ ]  I am very sensitive to cold, dry air.[ ]  I am exposed to tobacco smoke. (This includes being around people while they are smoking and being near people who have smoked after the last time they changed clothes.)[ ]  **Other:** Describe any other conditions or circumstances that increase my risk for asthma/asthma attack or indicate if there are none. |
| **These are the things supporters can do with and for me to help prevent asthma attacks:** | [ ]  Make sure I am not exposed to tobacco smoke, in the air or on people’s clothes. [ ]  Help me avoid contact with things that I am allergic to. [ ]  Make sure there is a humidifier available and working in my home. [ ]  Limit the amount of time I spend outside when the weather is very cold and dry. [ ]  Help me take all my daily prescribed medications for controlling my asthma, including inhalers. [ ]  If I have a spacer for inhalers, make sure I use it each time I take an inhaled medication. [ ]  Help me understand how to use an inhaler by practicing other tasks that also require me to inhale, like sucking through a straw. [ ]  Help me receive nebulizer treatments as my doctor ordered. [ ]  Help me take my medications for controlling GERD. [ ]  Make sure I have had my flu and pneumonia vaccinations as my doctor ordered. [ ]  **Other**: Describe any other asthma triggers I need to avoid to help prevent asthma attacks or indicate if there are none. |
| **When I start to experience an asthma exacerbation, these are the first signs:** | **If we act quickly, I am less likely to have a severe attack and I may not need as much medication to slow or stop my symptoms.** [ ]  My Peak Flow Meter (PFM) reading is below ### liters per minute. [ ]  I wake up at night. [ ]  I am letting you know I don’t want to do things I normally do, like walking or going outside. [ ]  I am wheezing, coughing, and/or I let you know that my chest doesn’t feel right. [ ]  I am asking for my rescue (PRN) inhaler. [ ]  I am not feeling better after using my inhaler or receiving a nebulizer treatment.[ ]  If I rely too much on my inhaler, I may need to see my doctor to get my asthma under better control. [ ]  **Other:** Describe any other early symptoms of an asthma attack, or indicate if there are none. |
| **These are the things supporters can do to help me when I am having an asthma flare up or attack:** | [ ]  Make sure that I have a rescue (PRN) inhaler with me at all times. [ ]  Help me use my rescue inhaler when I show early signs of an asthma attack. [ ]  Make sure that if I am having trouble breathing, **I SIT UP**. It is not safe for me to lie down when I am not breathing properly. [ ]  Notify my nurse as soon as I am stable enough and follow the nurse’s instructions. [ ]  **Other:** Describe any other strategies for helping me when I am having an asthma flare up or attack, or indicate if there are none. |
| **Documentation:**  | Describe the things that supporters should write down and where they should write them down. |
| **Nursing Intervention:** | Describe those things that must be done by the nurse relative to allergies and sensitivities, including those non-delegable duties listed in O.C.G.A. § 43-26-32 or HRST Q Score. |

**Signature of RN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 RN Typed Name and Agency

This healthcare plan is reviewed at least annually and promptly revised as my diagnosis/risk status changes.

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** [ ] Yes [ ] No

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