

**CHILDREN'S MEDICAL  
CENTER DALLAS**

1935 Medical District Drive · Dallas, Texas 75235  
(214) 456-7000

**PHYO**

**Asthma Management Program  
Physician Order Form and Patient  
Profile**

PHYO  
Form #

Rev. 07/2008

Child name / Nickname \_\_\_\_\_ Gender Male Female Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Primary language  English  Spanish  Other \_\_\_\_\_  
Guardian name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home phone number \_\_\_\_\_ Other contact number \_\_\_\_\_  
Insurance carrier \_\_\_\_\_ Policy number \_\_\_\_\_

**Asthma Assessment**

Date of last Primary Care Physician visit \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Asthma severity (NHLBI GUIDELINES)**  
 Intermittent  Mild persistent  Moderate persistent  Severe persistent  
**Asthma control (NHLBI GUIDELINES)**  
 Well controlled  Not well controlled  Very poorly controlled  
**Recent exacerbations**  
Date of last hospitalization for asthma \_\_\_\_/\_\_\_\_/\_\_\_\_  
Facility \_\_\_\_\_  
Date of last Emergency Room visit for asthma \_\_\_\_/\_\_\_\_/\_\_\_\_  
Facility \_\_\_\_\_

*Key: NHLBI= National Heart, Lung and Blood Institute*

**Co-Morbid Conditions**

Allergic rhinitis  Chronic sinusitis  Gastroesophageal reflux disease  
 Sleep apnea  Obesity  VCD  Immune deficiency

**Known asthma triggers:**

Allergies: \_\_\_\_\_  
Irritants: \_\_\_\_\_  
Other: \_\_\_\_\_

**Immunizations up to date**  Yes  No

**Drug allergies**  Yes  No List: \_\_\_\_\_

**Seen by a specialist?**  Yes  No

Name \_\_\_\_\_

**Psychosocial issues:**  No  Yes

**Prognosis:**  Good  Fair  Poor  Guarded

**Mental status:**  Age appropriate  Delayed  Other

**Safety concerns identified:**  No  Yes

(Fall, infection, oxygen, other)

**Diet restrictions:**  No  Yes

**Activity restrictions:**  No  Yes

**Functional limitations:**  No  Yes

*Key: PFT= Pulmonary Function Test*

**Child has:**

Peak flow meter  Yes  No nebulizer  Yes  No  
Holding chamber  Yes  No epi-pen  Yes  No  
Pillow encasements  Yes  No action plan  Yes  No  
Allergy testing  Yes  No recent PFT's  Yes  No

**Asthma Medications currently prescribed:**

Medication	Dosage	Route	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please enroll the above named patient in Children's Asthma Management Program which initiates ongoing biweekly contacts for care coordination, two home care visits by an RN, and an optional inter-disciplinary asthma class for caregivers.

**PHYSICIAN ORDERS**

- Instruct patient / caregiver in home management of disease process.
- Assess and instruct in signs and symptoms of asthma and potential complications.
- Assess patient response to medication and compliance with medication regimen.
- Assess and instruct patient / caregiver in medication regime, possible side effects, and any medication change noted by physician.
- Two (2) home care visits by an RN within 6 months. Discharge from home care services after the second home visit.
- Provide a holding chamber and peak flow meter to patient with instruction for proper use.
- Assess and instruct environmental controls for asthma management.
- Assess for home safety, adequate nutrition, hydration, and elimination.

Please identify any other asthma related concerns.

Signature / Title

Printed name

Office address

Off ice telephone

Off ice fax

Date

Time

**Please fax this form to: 214-456-2553**

If you have any questions or concerns please call:  
214-456-5864 (main line) or 214-456-8182 (MD line)