Wessex Asthma Network

Portsmouth Hospitals NHS NHS Trust

RAPID ACCESS ASTHMA CLINIC CRF INDEX		
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WELCOME - PATIENT DATA/HEIGHT/WEIGHT							
1. Patient Name							
	Address						
2. Patient's Date of Birth:		DD/MM/YYYY					
	Age						
3. Gender		☐ **Male** ☐ **Female**					
4. Height				.			**m**

5. Weight				.		**Kg**
6. BMI				.		**Kg/m^2**

STATION – MEDICAL REVIEW	
1. Asthma history including date of diagnosis	
Wheeze	☐ **Yes** ☐ **No**
Cough	☐ **Yes** ☐ **No**
Shortness of breath	☐ **Yes** ☐ **No**

2. Exacerbation history last 12 months			
Steroid courses – oral or IM	☐ **Yes**	☐ **No**	**Number** _____
Exacerbations managed by GP	☐ **Yes**	☐ **No**	**Number** _____
Exacerbations requiring nebuliser	☐ **Yes**	☐ **No**	**Number** _____
Attendances at ED	☐ **Yes**	☐ **No**	**Number** _____
Hospital admissions	☐ **Yes**	☐ **No**	**Number** _____
HDU/Respiratory High Care admissions	☐ **Yes**	☐ **No**	**Number** _____
ITU admission	☐ **Yes**	☐ **No**	**Number** _____

Hospital	**Admission Date**	**Discharge Date**

3. Allergy triggers		**Symptom on exposure, please tick**		
		Eyes*	**Nose***	**Chest***
House dust mite eg vacuuming, dusting		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Cat		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Cat at home	☐ **Yes** ☐ **No**			
Dog		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Dog at home	☐ **Yes** ☐ **No**			
Mould		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Grass		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Trees		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Other		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
*Eye symptoms – redness,itching, watering *Nasal symptoms – runny, itchy, stuffy nose/sneezing *Chest symptoms – wheeze, cough, chest tightness, breathlessness				

4. Other atopy	
Eczema	☐ **Yes** ☐ **No**
Migraine	☐ **Yes** ☐ **No**

5. Other asthma triggers – *Patient to complete*	
Infections (viral/common cold, etc.)	☐ **Yes** ☐ **No**
Cigarette smoke	☐ **Yes** ☐ **No**
Exercise	☐ **Yes** ☐ **No**
Stress	☐ **Yes** ☐ **No**
Temperature changes	☐ **Yes** ☐ **No**
Drugs (eg NSAIDs/beta blockers)	☐ **Yes** ☐ **No**
Food	☐ **Yes** ☐ **No**
Alcohol	☐ **Yes** ☐ **No**
Hormonal (pre-menstrual/pregnancy)	☐ **Yes** ☐ **No**
Other	☐ **Yes** ☐ **No**
Please specify: _____	

6. Occupation			
Retired	☐ **Yes** ☐ **No**	Unemployed	☐ **Yes** ☐ **No**
7. Any exposure to fumes, chemicals, aerosols or dust at work		☐ **Yes** ☐ **No**	
Details: _____			
8. Are asthma symptoms worse at work or improve on holiday		☐ **Yes** ☐ **No** ☐ **N/A**	
Details: _____			

9. Any hobbies that may cause exposure to allergic triggers, chemicals, dust, mould (eg horse riding, soldering, woodwind instruments, woodwork, DIY)	☐ **Yes** ☐ **No**
Details: _____	
10. Are asthma symptoms triggered by hobbies	☐ **Yes** ☐ **No** ☐ **N/A**
Details: _____	

11. Past medical history	
Cardiovascular disease	☐ **Yes** ☐ **No**
Please specify: _____	
Other respiratory disease	☐ **Yes** ☐ **No**
Please specify: _____	
ENT disease	☐ **Yes** ☐ **No**
Please specify: _____	
GI/abdominal disease	☐ **Yes** ☐ **No**
Please specify: _____	
Other	☐ **Yes** ☐ **No**

Please specify: _____   _____

12. Drug allergy	☐ **Yes**	☐ **No**
Details		
13. History of anaphylaxis	☐ **Yes**	☐ **No**
Details		

14. Current medications, inhalers, nebulisers, nasal sprays and topical medication including over the counter medication

Drug *Generic name in CAPITALS*	**Prescribed dose** *Include units and frequency*	**OTC or GP**	**Route** *Po/sc/pr/ patch/neb/ inh*	**With spacer** *Y/N/NA*	**Adherent** *Y/N*

15. Smoking status					
Current smoker	☐	**Pack years**	_____		
Ex-smoker	☐	Pack year defined as 20 cigarettes per day for 1 year			
Never smoked	☐				
16. If smoker, expired CO					**ppb**

STATION - SPIROMETRY

1. Lung function	**FEV1**	**Litres**
Attach spirometry chart below	**FEV1 % predicted**	**%**
	FVC	**Litres**
	FVC % predicted	**%**
	FEV1/FVC ratio	**%**
	Peak flow	**l/min**
	Predicted peak flow	**l/min**

2. FeNO				**ppb**

STATION – INHALER TECHNIQUE AND PEAK FLOW

1. Has patient brought their inhalers in		☐ **Yes** ☐ **No**
2. Inspiratory flow checked		☐ **Yes** ☐ **No**
3. Current inhaler devices	MDI alone	☐ L/Min
	MDI plus spacer	☐ L/Min

	Turbohaler	☐ L/Min
	Accuhaler	☐ L/Min
	Other please specify	☐ L/Min
4. Recommended inhaler device	MDI alone	☐
	MDI plus spacer	☐
	Turbohaler	☐
	Accuhaler	☐
	Other please specify	☐
5. Inhaler technique checked		☐ **Yes** ☐ **No**
6. Inhaler technique improved		☐ **Yes** ☐ **No**
7. Inhaler information sheet given		☐ **Yes** ☐ **No**
8. Peak flow (mini Wright) – add value to SMP on page 15		L/Min
9. Peak flow meter given		☐ **Yes** ☐ **No**

STATION - Patient Questionnaires	
1. ACQ 7 complete	☐ **Yes** ☐ **No**
NB. include item 7 FEV1 %predicted	Score:
2. AQLQ complete	☐ **Yes** ☐ **No**
	Score:
3. SNOT 22 complete	☐ **Yes** ☐ **No**
	Score:

4. Epworth complete	☐ **Yes** ☐ **No**
	Score:
5. HADS complete	☐ **Yes** ☐ **No**
	Score: **Anxiety** ☐ **Depression** ☐
6. Nijmegen complete	☐ **Yes** ☐ **No**
	Score:
7. GERDQ complete	☐ **Yes** ☐ **No**
	Score:
8. Patient survey complete	☐ **Yes** ☐ **No**
	Score:

STATION – Skin Prick Testing and SMP

1. ANY HISTORY OF ANAPHYLAXIS? ***IF YES, AVOID SKIN PRICK TEST***			☐ **Yes** ☐ **No**
2. On antihistamines? ***If yes, interpret with caution***			☐ **Yes** ☐ **No**
3. Type of test	Result (please circle)		Wheal (size in mm)
Positive control	positive	negative	X mm
Negative control	positive	negative	X mm
Cat	positive	negative	X mm
Dog	positive	negative	X mm
House dust mite	positive	negative	X mm
Aspergillus	positive	negative	X mm

Grass pollen	positive	negative	X mm
Tree pollen	positive	negative	X mm

QUESTIONAIRRES	
1. Remind patient to complete questionnaires	☐ **Yes** ☐ **No**

SMP	
1. Self-management plan devised	☐ **Yes** ☐ **No**
2. Peak flow on mini Wright (see page 12)	
3. Predicated peak flow	
4. Peak flow 75 – 85%	
5. Peak flow 50 – 75%	
6. Peak flow <50%	

STATION – Education session	
1. Patient attended	☐ **Yes** ☐ **No**
2. Partner or Carer(s) attended	☐ **Yes** ☐ **No**

Education content	
1. Asthma education and triggers	☐ **Yes** ☐ **No**
2. Asthma self-management	☐ **Yes** ☐ **No**
3. Smoking cessation	☐ **Yes** ☐ **No**

SMP	
Self-management plan devised	☐ **Yes** ☐ **No**

OUTCOME - Diagnosis		
1. Asthma?		☐ **Yes** ☐ **No**
If no, please specify		
2. Controlled?		☐ **Yes** ☐ **No**
3. Allergic?		☐ **Yes** ☐ **No**
4. Inflammation?		☐ **Yes** ☐ **No**
5. Co - morbidity?		☐ **Yes** ☐ **No**
	GORD?	☐ **Yes** ☐ **No**
	Rhinosinusitis?	☐ **Yes** ☐ **No**
	Other?	☐ **Yes** ☐ **No**
Details		

OUTCOME - Treatment	
1. Any recommended change to inhaled medication?	☐ **Yes** ☐ **No**
	☐ **Step up** ☐ **Step down**
If yes, please specify:	
2. Any recommended change to medication adherence?	☐ **Yes** ☐ **No**
If yes, please specify:	

3. Any recommended change to other medications?		☐ **Yes** ☐ **No**
	PPI	☐ **Yes** ☐ **No**
	Nasal corticosteroid	☐ **Yes** ☐ **No**
	Antihistamine	☐ **Yes** ☐ **No**
	Other	☐ **Yes** ☐ **No**
Details:		

OUTCOME – Follow up	
1. Further investigations recommended?	☐ **Yes** ☐ **No**
Details:	
2. Follow up recommendations	
GP follow up *(with 1-year plan)*	☐ **Yes** ☐ **No**
Research clinic follow up	☐ **Yes** ☐ **No**
SAAC follow up	☐ **Yes** ☐ **No**
Referral to other secondary care *(GP to refer)*	☐ **Yes** ☐ **No**
Details:	

SECTION 1 FeNO and exhaled CO	
FeNO	**ppb**
CO	**ppb**

SECTION 2 - QUESTIONAIRRES		
1. ACQ complete		☐ **Yes** ☐ **No**
	Score:	
2. AQLQ complete		☐ **Yes** ☐ **No**
	Score:	
3. SNOT 22 complete (OPTIONAL)		☐ **Yes** ☐ **No**
	Score:	
4. Epworth complete (OPTIONAL)		☐ **Yes** ☐ **No**
	Score:	
5. HADS complete (OPTIONAL)		☐ **Yes** ☐ **No**
	Score: **Anxiety** ☐	**Depression** ☐
6. Nijmegen complete (OPTIONAL)		☐ **Yes** ☐ **No**
	Score:	
7. GERDQ complete (OPTIONAL)		☐ **Yes** ☐ **No**
	Score:	

SECTION 3 - ASTHMA HISTORY	
1.Review of asthma history	Triggers Exacerbations Medication Occupation Hobbies Co morbidity Reflux Past medical history smoking

2. Relevant past medical history

3. Drug allergy	☐ **Yes** ☐ **No**
Details	
4. History of anaphylaxis	☐ **Yes** ☐ **No**
Details	

5. Current medications, inhalers, nebulisers, nasal sprays and topical medication including over the counter medication

Drug *Generic name in CAPITALS*	**Prescribed dose** *Include units and frequency*	**OTC or GP**	**Route** *Po/sc/pr/ patch/neb/ inh*	**With spacer** *Y/N/NA*	**Adherent** *Y/N*

SECTION 4 - RADIOLOGY	
1. Chest x-ray	☐ **Yes** ☐ **No**
Result:	
2. HRCT	☐ **Yes** ☐ **No**
Result:	
3. CT sinus	☐ **Yes** ☐ **No**

Result:

SECTION 5 - PATHOLOGY		
1. Blood tests taken today		☐ **Yes** ☐ **No**
Please specify:		
Test	**Date**	**Result**
WCC		
Eosinophils		
Total IgE		
Aspergillus IgE		
Aspergillus IgG		

2. Skin Prick test			
Skin prick test done at RAAC			☐ **Yes** ☐ **No**
Result:			
If no or inconclusive then repeat or send venous sample			
3. ANY HISTORY OF ANAPHYLAXIS? ***IF YES, AVOID SKIN PRICK TEST***			☐ **Yes** ☐ **No**
4. On antihistamines? ***If yes, interpret with caution***			☐ **Yes** ☐ **No**
5. Type of test	Result (please circle)		Wheal (size in mm)
Positive control	positive	negative	X mm

Negative control	positive	negative	X mm
Cat	positive	negative	X mm
Dog	positive	negative	X mm
House dust mite	positive	negative	X mm
Aspergillus	positive	negative	X mm
Grass pollen	positive	negative	X mm
Tree pollen	positive	negative	X mm
	positive	negative	X mm
	positive	negative	X mm
	positive	negative	X mm
	positive	negative	X mm
	positive	negative	X mm
	positive	negative	X mm

SECTION 6 - LUNG FUNCTION		
1. Spirometry	☐ **Yes**	☐ **No**
2. Lung volume	☐ **Yes**	☐ **No**
3. Resistance	☐ **Yes**	☐ **No**
4. Reversibility	☐ **Yes**	☐ **No**
Please file lung function report in notes		

SECTION 7 - INHALER TECHNIQUE AND SMOKING CESSATION		
1. Has patient brought their inhalers in	☐ **Yes**	☐ **No**
2. Inspiratory flow checked	☐ **Yes**	☐ **No**

3. Current inhaler devices	MDI alone	☐ L/Min
	MDI plus spacer	☐ L/Min
	Turbohaler	☐ L/Min
	Accuhaler	☐ L/Min
	Other please specify	☐ L/Min
4. Recommended inhaler device	MDI alone	☐ L/Min
	MDI plus spacer	☐ L/Min
	Turbohaler	☐ L/Min
	Accuhaler	☐ L/Min
	Other please specify	☐ L/Min
5. Inhaler technique checked		☐ **Yes** ☐ **No**
6. Inhaler technique improved		☐ **Yes** ☐ **No**
7. Inhaler information sheet given		☐ **Yes** ☐ **No**

8. Smoking cessation advice given	☐ **Yes** ☐ **No** ☐ **N/A**
Details:	

SECTION 8 - DIETICIAN

BMI			**.**		**Kg/m²**		**Triggers**
							Salicylates
							Sulphites
							Reflux

	Oral allergy **Weight**

SECTION 9 - PHYSIOTHERAPY	
Nijmegen /64	

SECTION 10 - PSYCHOLOGY		
HADS Score:	**Anxiety**	**Depression**

SECTION 11 - ENT		
SNOT 22 score	**Nasendoscopy**	☐ **Yes** ☐ **No**

SECTION 12 – EXIT MEDICAL REVIEW

SECTION 13 - MDT
Case summary- Medical
Lung function
Inhaler technique
Dietician
Physiotherapy

Psychology	
ENT	
Co morbidities	
a. Rhinitis	☐ **Yes** ☐ **No** ☐ **Possible**
b. Food Allergy	☐ **Yes** ☐ **No** ☐ **Possible**
c. Anxiety/Depression	☐ **Yes** ☐ **No** ☐ **Possible**
d. GORD	☐ **Yes** ☐ **No** ☐ **Possible**
e. Hyperventilation	☐ **Yes** ☐ **No** ☐ **Possible**
f. Obesity	☐ **Yes** ☐ **No**
g. VCD	☐ **Yes** ☐ **No** ☐ **Possible**
h. ABPA	☐ **Yes** ☐ **No** ☐ **Possible**
i. Asthma/COPD overlap syndrome	☐ **Yes** ☐ **No** ☐ **Possible**
j. NSAID sensitivity	☐ **Yes** ☐ **No** ☐ **Possible**
k. Eczema	☐ **Yes** ☐ **No** ☐ **Possible**
Any other significant co-morbidities likely to affect asthma: _____ _____ _____	

MDT RECOMMENDATIONS
Medication
Investigations
Follow up
Research