



= YES = NO

(PLACE PATIENT LABEL HERE)

SURNAME: _____ NHI: _____

FIRST NAMES: _____

Date of Birth: ____ / ____ / ____ SEX: _____

ADULT ASTHMA

Date: ____ / ____ / 20 Time: _____ Clinician: NP CNS HS Reg SMO

PRESENTING COMPLAINT

Duration of symptoms

Cough No Yes: Productive No Yes:

Wheeze No Yes:

Shortness of breath No Yes:

Salbutamol home use: No Yes:

Inhaler Nebuliser:

GP visits: No Yes:

Known triggers: Exercise Cold Viral Allergens

Other:

Pregnant → High risk. Ensure senior clinician aware of pregnancy. Think of PE and amniotic fluid emboli

RELEVANT PAST MEDICAL HISTORY

Asthma control / risk stratification

Previous ICU admits: No Yes: When:

Intubated: No Yes:

NIV: No Yes:

Last 12 months: Oral steroids:

ED visits:

Hospital admits:

Other history

Recurrent attender (> 3 / year) is a risk factor

MEDICATIONS / ALLERGIES See EM CeDDS for common inhalers

Nil known allergies ALLERGIES:



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SOCIAL HISTORY

SMOKING Hx: Non-Smoker Ex-smoker Current smoker Pack years: _____

Cigs per day: _____

Living situation: Alone With: _____

Transport: Access to car: Yes No

Access to phone: Yes No

Social isolation is a risk factor for fatal asthma

VITAL SIGNS

BP _____ mmHg

Resp Rate _____ / min

Pain score ____ /10

Pulse _____ bpm

SPO2 _____ %

Temp _____ °C

Air NP Hudson: ____ l/min

General NOT distressed

Dehydration None Mild Moderate Severe

Jaundice Pallor Cyanosis Clubbing LN's Oedema

EXAMINATION

ENT

Nose Normal

Pharynx Normal

CVS Warm and well perfused

Cap refill Normal

Pulses Normal

S1S2 Normal

RESP

Distressed No Yes:

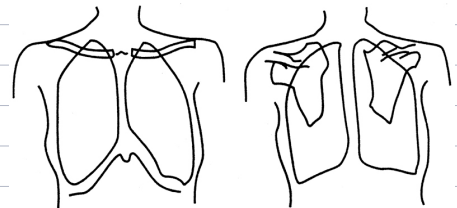
Posture Normal Tripod position Splinting

Breathing work Normal Increased Accessory muscle use

Speech Normal Short sentences Words only

Wheeze None Expiratory Inspiratory

Air entry Equal



Look for: grunting, signs of pneumothorax, consolidation or severe respiratory distress

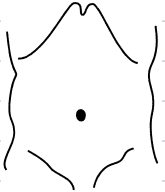
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EXAMINATION	
ABD	
Appearance <input type="checkbox"/> Not distended	
Palpation <input type="checkbox"/> Soft	
NEURO	
GCS ____ /15 <input type="checkbox"/> Alert and orientated	<i>Drowsiness is a sign of hypercapnoea</i>
OTHER	
Signs of DVT <input type="checkbox"/> No <input type="checkbox"/> Yes:	

BLOOD RESULTS								<input type="checkbox"/> N/A	
HAEMATOLOGY			BIOCHEMISTRY					ABG (on air / FiO2)	
Hb			Na ⁺		CRP			pH	
WCC			K ⁺		β-HCG			PCO ₂	
PL			Gluc					HCO ₃	
			Creat					BE	
								Lactate	

INDICATIONS FOR CXR	
<input type="checkbox"/> First presentation with wheeze	<input type="checkbox"/> ? Alternative diagnosis - ? foreign body
<input type="checkbox"/> Signs of pneumothorax	<input type="checkbox"/> Underlying lung conditions
<input type="checkbox"/> Signs of consolidation	<input type="checkbox"/> > 5/7 History
<input type="checkbox"/> Severe asthma	<input type="checkbox"/> Clinician concern

RADIOLOGY <i>see indications above</i>	<input type="checkbox"/> Not indicated
CXR Lung fields <input type="checkbox"/> Normal	
Cardiac size <input type="checkbox"/> Normal	
Consolidation <input type="checkbox"/> No <input type="checkbox"/> Yes:	
Pneumothorax <input type="checkbox"/> No <input type="checkbox"/> Yes:	

EMERGENCY MEDICINE NOTES



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CLINICAL IMPRESSION / DIAGNOSIS / PLAN

Diagnosis: Non-infective exacerbation Asthma DDx includes:
 Infective exacerbation Asthma
 Ran out of meds
 Other:

FURTHER MANAGEMENT / NURSING INSTRUCTION *document individualised instructions here*

Rx: Continue chosen pathway *or* Care as individualised below
Oral steroids given: Yes No Reason if not: _____

EMERGENCY MEDICINE NOTES

TRANSFER OF CARE

Discharge to GP: Discharge criteria & checklist on page 7 Best Care Bundle pathway
Maintenance Rx: Does your patient meet criteria to step up Rx? Indications & formulary p 7&8 best care bundle
 Yes: Stepped up to: _____
Follow up: GP follow up for all
 Resp CNS referral Yes No *Consider for all patients on the moderate pathway. Ext 42765 in hours or fax yellow referral to 42348 for community follow up*
Check: Follow up / patient information sheet given & discussed
Access to: Car Phone
 In care of responsible adult
 Admission: Interim nursing plan documented

Clinician Name: _____ Designation: _____ Sign: _____ Contact details: _____
For junior staff: Discussed with Reviewed by SMO Dr : _____ Sign: _____