

**New York State Department of Health
Healthy Neighborhoods Program
Home Intervention Form**

COUNTY	<input type="text"/>	ID#	<input type="text"/>
Visit Type: <input type="radio"/> Initial <input type="radio"/> Revisit			Pilot: <input type="radio"/>

Reason for Visit:

Neighborhood Canvass Tenant Complaint Referral (from) _____

Initial Visit First Attempt:

Date / /

Initiated Refused No one home Vacant

Revisit First Attempt:

Date / /

Initiated Refused No one home Moved Vacant

Initial Visit Second Attempt:

Date / /

Initiated Refused No one home Vacant

Revisit Second Attempt:

Date / /

Initiated Refused No one home Moved Vacant

Initial Visit Third Attempt:

Date / /

Initiated Refused No one home Vacant

Revisit Third Attempt:

Date / /

Initiated Refused No one home Moved Vacant

Surveyor:

First name	_____ <input type="text"/>	Lastname	_____ <input type="text"/>
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Number of asthma assessment forms included

0 1 2 3 4 5 6 7 8 9 10

Housing information (Initial Visit Only):

Rent, private Rent, public Own Unknown
 If rental, renter receives: Rental Assistance Section 8 Unknown
 Building is owner occupied? Yes No Unknown
 Units in building 1 2 3 4 5 >5
 Age of Building Post-1978 1950-1978 Pre-1950 Unknown

Household Information

Race of respondent? (choose all that apply)
 White Black or African American American Indian or Native American
 Asian Other _____ Unknown
 Is the respondent Spanish/Hispanic/Latino? Yes No Unknown
 Does respondent have high school diploma or GED? Yes No Unknown
 Does anyone in the household receive food stamps or public assistance? Yes No Unknown



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COUNTY ID#
 Visit Type: Initial Revisit

Adults (>=18 years old)		INITIAL VISIT ONLY			ALL VISITS		Ever been advised to quit smoking by a medical professional?
		Age	Sex	Asthmatic? *	Does this person smoke?		
Respondent 1	1	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U		<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Adult number 2	2	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U		<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Adult number 3	3	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U		<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Adult number 4	4	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U		<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Adult number 5	5	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U		<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Adult number 6	6	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U		<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Adult number 7	7	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U		<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Adult number 8	8	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U		<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Adult number 9	9	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U		<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Adult number 10	10	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U		<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Children (0-17 years old)					Ever been advised to quit smoking by a medical professional?		
		Age	Sex	Asthmatic? *	Does this person smoke?	Ever tested for lead?	
Child number 1	1	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Child number 2	2	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Child number 3	3	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Child number 4	4	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Child number 5	5	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Child number 6	6	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Child number 7	7	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Child number 8	8	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Child number 9	9	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
Child number 10	10	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U

* Use your own judgment to continue with the asthma questions and intervention. Use the asthma screening questions on the Asthma Information Sheet as a guide to identify residents with asthma or asthma symptoms.



New York State Department of Health Healthy Neighborhoods Program Home Intervention Form

COUNTY ID#

Visit Type: Initial Revisit

Tobacco Control	Y	I	N	U
1) Does anyone smoke in the home or is there evidence of smoking (ashtrays, smell)? (If no, skip #2-4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Is smoking allowed in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Is smoking limited to certain rooms inside the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) Has anyone taken the Smoke Free Home Pledge?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Fire Safety	Y	I	N	U
1) Does residence have functional smoke detector(s) on every floor with living space?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Is a smoke detector audible from each sleeping space?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Is there a functional smoke detector in the common areas of multi-dwelling buildings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) Is there a functional fire extinguisher?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) Do exits function properly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6) Are there any electrical hazards?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7) Are there improperly stored flammables?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8) Are EDITH practiced?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Lead (Pre-1978 dwellings only)	Y	I	N	U
1) Did tenant receive <i>Protect Your Family From Lead in Your Home?</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Were any renovations done recently?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Is there chipping, peeling, deteriorated, chalking paint indoors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) Is there chipping, peeling, deteriorated, chalking paint outdoors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) Has an elevated blood lead level been investigated by DOH at this address?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Indoor Air Quality	Y	I	N	U
1) Is there a working carbon monoxide detector?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Carbon monoxide reading ppm	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3) Are there any malfunctioning appliances that could result in an indoor air hazard?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) Is the furnace/heat source filter dirty or missing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) Is a humidifier or vaporizer used?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6) Temperature (indoor reading) °F	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7) Relative humidity (indoor reading) %	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8) Does every room have ventilation (windows open/bathroom ventilated)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9) Is there a chemical smell indoors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10) Is there an odor from scented home products?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11) Has the building been tested for radon?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Tobacco Control Interventions	(check all that apply)					Evidence
	Ref	Edu	Bro	Prod	Other	
1) Fax-to-Quit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Smokers' Quitline	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Smoking cessation kit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) Smoke Free Home Pledge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) Other cessation programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Fire Safety Interventions	(check all that apply)					Evidence
	Ref	Edu	Bro	Prod	Other	
1) Battery for smoke detector	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Electrical cover plate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Electrical fuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) Fire Extinguisher	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) Multi-outlet strip with circuit breaker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6) Smoke Detector	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7) EDITH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Lead Interventions	(check all that apply)					Evidence
	Ref	Edu	Bro	Prod	Other	
1) Lead-safe cleaning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Lead-safe work practices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Lead-safe work training course	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Indoor Air Quality Interventions	(check all that apply)					Evidence
	Ref	Edu	Bro	Prod	Other	
1) CO detector	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Battery for CO detector	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Furnace filter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) Radon kit placed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) Thermometer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments



New York State Department of Health
Healthy Neighborhoods Program
Home Intervention Form - Asthma Assessment

COUNTY	<input type="text"/>	ID#	<input type="text"/>
Visit Type	<input type="radio"/> Initial	<input type="radio"/> Revisit	
	<input type="radio"/> Adult	<input type="radio"/> Child	- <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10

Complete this form for each adult or child with asthma or asthma symptoms.*
Asthma revisits should be made 3-6 months after the last asthma visit.

Potential asthma triggers	Status
1) Does anyone smoke inside the home?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
2) Is there evidence of significant dust accumulation?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
3) Are there rats? (evidence or reported)	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
4) Are there mice? (evidence or reported)	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
5) Are there cockroaches? (evidence or reported)	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
6) Is there evidence of mold or mildew?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
7) Are there any pets with fur or feathers?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
8) If yes to pets, does s/he sleep in the same room as the pet(s) with fur or feathers?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U

Asthma diagnosis and symptoms	Status
1) Has s/he ever been told by a doctor or other health professional that s/he has asthma?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
2) Number of days that s/he had asthma attacks, episodes or worsening asthma symptoms:	in past 3 months <input type="text"/>
3) Number of visits to a doctor or other health professional for worsening asthma or an asthma attack:	in past 12 months <input type="text"/>
4) Number of overnight stays in the hospital because of asthma:	in past 12 months <input type="text"/>
5) Number of visits to an ER or urgent care center because of asthma:	in past 12 months <input type="text"/>
6) Number of days of daycare, school, or work missed by this asthmatic because of his/her asthma:	in past 3 months <input type="text"/>
7) Number of days of school or work missed by other family members because of this asthmatic's asthma:	in past 3 months <input type="text"/>

Comments:

Asthma management	Status
1) Has any other household member ever been told that smoking in the home affects asthma?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
2) Does s/he have a primary medical care provider?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
3) Does s/he have health insurance?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
4) Does s/he have medicine prescribed by a doctor for "quick relief"? *	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
4a) If yes, how many times in the past week did s/he take his/her "quick relief" medicine?	<input type="text"/>
5) Does s/he have medicine prescribed by a doctor for controlling his/her asthma? *	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
5a) If yes, did s/he take the "controller" medication every day in the past week?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
6) Does s/he feel that their asthma is well controlled?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
7) Does s/he use a peak flow meter?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
8) Does s/he have a current written asthma management (or action) plan?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
9) Does s/he (or parent of her/him) know the early warning signs of worsening asthma?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
10) Does s/he know what to do if his/her asthma gets worse?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
11) Does s/he know the triggers that make his/her asthma worse?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U
12) Does s/he know what to do to get rid of or avoid asthma triggers?	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> O <input type="radio"/> U

Asthma education, products, and referrals provided	Given	Evidence
1) Verbal and written information:		
a) About asthma	<input type="radio"/>	<input type="radio"/>
b) About asthma triggers	<input type="radio"/>	<input type="radio"/>
c) About smoking & asthma triggers	<input type="radio"/>	<input type="radio"/>
2) Hypoallergenic pillow covers	<input type="radio"/>	<input type="radio"/>
3) Hypoallergenic mattress covers	<input type="radio"/>	<input type="radio"/>
4) Blank asthma management (or action) plan form	<input type="radio"/>	<input type="radio"/>
5) Referral for asthma services or resources	<input type="radio"/>	<input type="radio"/>
6) Referral for primary care provider	<input type="radio"/>	<input type="radio"/>
7) Referral for health insurance coverage	<input type="radio"/>	<input type="radio"/>
8) Other (specify in Comments)	<input type="radio"/>	<input type="radio"/>

* For help in explaining asthma attacks, quick relief and controller medicines, or written asthma management plan, refer to the Asthma Information Sheet.

