CHINESE

幼兒哮喘治療計劃

0-5歲

Patient Name: _____

Medical Record #: _____

DOB: _____

醫療保健機構名稱: _____

醫療保健機構電話: _____ 填表人: _____ 日期: _____

病癥控制藥物 （每天使用以保持健康）	使用劑量	使用次數	其他説明 （如間隔器/面罩、噴霧器）
		_____ 每天次數 **每天使用！**	
		_____ 每天次數 **每天使用！**	
		_____ 每天次數 **每天使用！**	
		_____ 每天次數 **每天使用！**	

快速解喘藥物	使用劑量	使用次數	其他説明
		儘在需要時使用	注：如果需要經常使用本藥（_____每周次數），請打電話給醫生。

綠色區

孩子感到**舒適**，即使在活躍的活動中也沒有哮喘癥狀。

預防每天的哮喘癥狀:

- 每天使用上述的控制藥物。
- 避免孩子接觸使哮喘惡化的東西。

☑ 避免接觸抽煙的煙霧，要求吸煙者到戶外抽煙。

☐ _____

☐ _____

黃色區

孩子感到**不舒適**，並有以下的哮喘癥狀:

- 咳嗽
- 喘息
- 流鼻涕或有其他感冒癥狀
- 呼吸困難或加快
- 由於咳嗽和呼吸困難而無法入睡
- 比平時活動減少
- _____
- _____

顯示孩子呼吸有困難的癥狀可能包括: 難以餵食、（打呼嚕、無力吸奶）、睡眠習慣變化、脾氣急躁並顯疲憊，食慾不振。

注意。繼續使用**每天**的正常哮喘藥物及:

☐ 使用 _____

_____ (include dose and frequency)

如果孩子不在**綠色區**並在一個小時之後仍有癥狀，那麼:

☐ 更多使用 _____

_____ (include dose and frequency)

☐ _____

_____ (include dose and frequency)

☐ 打電話 _____

紅色區

孩子**感覺極壞！**

預警癥狀包括:

- 即使在使用黃色區的藥物之後，孩子的喘息、咳嗽或呼吸困難仍持續或加劇。
- 孩子的呼吸非常困難並妨礙其行走、講話、進食或玩耍。
- 孩子發睏或沒有平時那麼警覺。

危急癥狀！立即求助！

☐ 速帶孩子去醫院或立即打911電話！

☐ 更多使用 _____ (include dose and frequency)
直到得到援助。

☐ 使用 _____ (include dose and frequency)

請打911電話，如有以下情況:

- 孩子頸部或肋骨的皮膚出現內陷；或
- 孩子的嘴唇和/或指甲變灰或發青；或
- 孩子沒有反應。

情況危急！ 請立即求助！

ORIGINAL (Patient) / CANARY (Child Care / School / Other Support Systems) / PINK (Chart)

PROVIDER INSTRUCTIONS FOR ASTHMA ACTION PLAN (Children ages 0-5)

☐ **DETERMINE THE LEVEL OF ASTHMA SEVERITY** (see Table 1)

☐ **FILL IN MEDICATIONS**

Fill in medications appropriate to that level (see Table 1) and include instructions, such as "shake well before using", "use with spacer", and "rinse mouth after using".

☐ **ADDRESS ISSUES RELATED TO ASTHMA SEVERITY**

These can include allergens, smoke, rhinitis, sinusitis, gastroesophageal reflux, sulfite sensitivity, medication interactions, and viral respiratory infections.

☐ **FILL IN AND REVIEW ACTION STEPS**

Complete the recommendations for action in the different zones, and review the whole plan with the family so they are clear on how to adjust the medications, and when to call for help.

☐ **DISTRIBUTE COPIES OF THE PLAN**

Give the top copy of the plan to the family, the next one to school, day care, caretaker, or other involved third party as appropriate, and file the last copy in the chart.

☐ **REVIEW ACTION PLAN REGULARLY (Step Up / Step Down Therapy)**

A patient who is always in the green zone for some months may be a candidate to "step down" and be reclassified to a lower level of asthma severity and treatment. A patient frequently in the yellow or red zone should be assessed to make sure inhaler technique is correct, adherence is good, environmental factors are not interfering with treatment, and alternative diagnoses have been considered. If these considerations are met, the patient should "step up" to a higher classification of asthma severity and treatment. Be sure to fill out a new asthma action plan when changes in treatment are made.

TABLE 1: Severity and medication chart (classification is based on meeting at least one criterion)

	Severe Persistent	Moderate Persistent	Mild Persistent	Mild Intermittent
Symptoms/Day	Continual symptoms	Daily symptoms	> 2 days/week but < 1 time/day	≤ 2 days/week
Symptoms/Night	Frequent	> 1 night/week	> 2 nights/month	≤2 nights/month
Long Term Control[1]	**Preferred treatment:** • Daily *high-dose* inhaled corticosteroid **AND** • Long-acting inhaled B_2 - agonist **AND, if needed:** • Corticosteroid tablets or syrup long term (2 mg/kg/day, generally do not exceed 60 mg per day). (Make repeated attempts to reduce systemic corticosteroids and maintain control with high-dose inhaled corticosteroids.) ***Consultation With Asthma Specialist Recommended***	**Preferred treatment:** • Daily *low-dose* inhaled corticosteroid and long-acting inhaled B_2 - agonist **OR** • Daily *medium-dose* inhaled corticosteroid **Alternative treatment:** • Daily *low-dose* inhaled corticosteroid and either leukotriene receptor antagonist or theophylline …… **If needed** (particularly in patients with recurring severe exacerbations): **Preferred treatment:** • Daily *medium-dose* inhaled corticosteroid and long-acting B_2 – agonist **Alternative treatment:** • Daily *medium-dose* inhaled corticosteroid and either leukotriene receptor antagonist or theophylline ***Consultation With Asthma Specialist Recommended***	**Preferred treatment:** • Daily *low-dose* inhaled corticosteroid (with nebulizer or MDI with holding chamber with or without face mask or DPI) **Alternative treatment:** • Cromolyn (nebulizer is preferred or MDI with holding chamber) **OR** • Leukotriene receptor antagonist **Note:** Initiation of long-term controller therapy should be considered if child has had more than three episodes of wheezing in the past year that lasted more than one day and affected sleep and who have risk factors for the development of asthma.[2] ***Consider Consultation With Asthma Specialist***	**No** daily medication needed.
Quick Relief[1]	**Preferred treatment:** • Inhaled short-acting B_2- agonist **Alternative treatment:** • Oral B_2 - agonist	**Preferred treatment:** • Inhaled short-acting B_2 - agonist **Alternative treatment:** • Oral B_2 - agonist	**Preferred treatment:** • Inhaled short-acting B_2 - agonist **Alternative treatment:** • Oral B_2 - agonist	**Preferred Treatment:** • Inhaled short-acting B_2-agonist **Alternative Treatment** • Oral B_2 - agonist

1 For Infants and children use spacer or spacer AND MASK.
2 Risk factors for the development of asthma are parental history of asthma, physician-diagnosed atopic dermatitis, or two of the following: physician-diagnosed allergic rhinitis, wheezing apart from colds, peripheral blood eosinophilia.
With viral respiratory infection, use bronchodilator every 4-6 hours up to 24 hours (longer with physician consult); in general no more than once every six weeks.
If patient has seasonal asthma on a predictable basis, long-term anti-inflammatory therapy (inhaled corticosteroids, cromolyn) should be initiated prior to the anticipated onset of symptoms and continued through the season.

This Asthma Plan was developed by a committee facilitated by the Childhood Asthma Initiative, a program funded by the California Children and Families Commission, and the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. This plan is based on the recommendations from the National Heart, Lung, and Blood Institute's, "Guidelines for the Diagnosis and Management of Asthma," NIH Publication No. 97-4051 (April 1997) and "Update on Selected Topics 2002," NIH Publication No. 02-5075 (June 2002). *The information contained herein is intended for the use and convenience of physicians and other medical personnel, and may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by qualified medical personnel in light of available resources and the circumstances presented by individual patients. No entity or individual involved in the funding or development of this plan makes any warranty guarantee, express or implied, of the quality, fitness, performance or results of use of the information or products described in the plan or the Guidelines.* *For additional information, please contact RAMP at (510)622-4438 , <http://www.rampasthma.org>.*