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EPISODE NUMBER: Please state the number of episodes in the last 12 months from 1 upwards. PLEASE USE A SEPARATE FORM FOR EACH EPISODE. FORM NUMBER: \_\_\_\_

# National Review of Asthma Deaths (NRAD) A2 Primary care past asthma attack (supplementary form)

V1 010312

### ABOUT THE NRAD

The NRAD team at the Royal College of Physicians (RCP) will collect data on all people who have died from asthma in the UK between 1 February 2012 and 31 January 2013.

The aim of the NRAD is to understand why people of all ages die from asthma so that recommendations can be made to prevent deaths from asthma in the future.

Your support in the completion of this form is extremely important. Participation in national audits and confidential enquiries provides you with high-quality evidence for appraisal, revalidation and continuing professional development (CPD) documentation. The RCP will provide you with a certificate to confirm your participation in this project. Please keep a record of this number of hours you contribute so that we can do this accurately.

PLEASE REFER TO FORM 1 – NOTIFICATION SUMMARY ENCLOSED FOR PATIENT DETAILS.

NRAD CASE ID: \_\_/\_\_\_\_ (USE THIS CODE FOR ALL FUTURE CORRESPONDENCE).

### HOW TO COMPLETE AND RETURN THIS FORM

- Please complete one form for each episode of acute or controlled asthma for which the patient was treated in the practice (please include those patients who were treated with a short course of oral steroids or high-dose bronchodilators (via nebuliser or spacer device)).
- Certain sections may not be applicable to all patients. Please read the guidance before completing.
- Please complete the form using the information available in the patient’s notes. Complete all dates in the format DD/MM/YYYY and times using the 24-h clock, eg 18.50.
- If no data are recorded, or the information is missing or not known, please select ‘Not recorded’.
- Please keep a copy of this form for your records. Return copies of complete forms to the NRAD office.

By email: [rachael.davey@nhs.net](mailto:rachael.davey@nhs.net)

By mail (MUST BE SENT SECURELY AND MARKED AS CONFIDENTIAL): NRAD, House 1, Royal College of Physicians, 11 St Andrews Place, London NW1 4LE

If you have any queries about completing or returning this form, please contact the NRAD team via [nrad@rcplondon.ac.uk](mailto:nrad@rcplondon.ac.uk) or telephone 020 3075 1500 or 1522.

### PREVIOUS ASTHMA ATTACKS – WITHIN 12 MONTHS PRIOR TO DEATH

Definition: An asthma attack is defined for the purpose of this review as: any patient consulting a health professional (or self treating themselves according to an agreed asthma self-management/action plan) for an episode of uncontrolled asthma. (including consultations: where systemic steroids were prescribed, high-dose bronchodilators were used – either by spacer or nebuliser); or simply where patients consulted because they had experienced increased symptoms of their asthma).

### PATIENT DETAILS

NRAD Case ID: \_\_/\_\_\_\_

Age: \_\_\_\_ years \_\_\_\_ months

A) How many asthma attacks did this patient have in the 12 months before death? \_\_\_\_  Not known

B) How many of these were treated by:

- A health professional in your practice \_\_\_\_  Not known
- A health professional elsewhere \_\_\_\_  Not known
- The patient themselves or by a family member \_\_\_\_  Not known

Please note that the NRAD project has approval from the National Information Governance Board (NIGB) under Section 251 of the NHS Act (2006) to collect patient identifiable information without consent. Approval reference: ECC 8-02(FT2)/2011

## SECTION 1: DATES/TIMES

### 1.1 Date of attack:

\_\_/\_\_/\_\_\_\_ (DD/MM/YYYY)

### 1.2 Place treated: *(tick all that apply)*

Primary care

Paramedic

Emergency department

Urgent care centre

Inpatient hospital

ICU

Not known

Other, please specify \_\_\_\_\_

### 1.3 Date of onset of symptoms:

*(eg cough, wheeze, shortness of breath)*

\_\_/\_\_/\_\_\_\_ (DD/MM/YYYY)

Not recorded

### 1.4 Time of onset of symptoms:

*(eg cough, wheeze, shortness of breath)*

\_\_:\_\_ (24-h clock)

Not recorded

## SECTION 5.3: EVENTS LEADING UP TO ATTACK (AS PER BTS 10+12 SYMPTOMS/RISK FEATURES)

### 5.3.1 Were there any possible precipitating or exacerbating factors in this attack?

Yes → [Go to 5.3.1.1](#)  No → [Go to 5.3.2](#)  Not known → [Go to 5.3.2](#)

#### 5.3.1.1 If yes, please specify: *(tick all that apply)*

Food allergy (eg dairy, eggs, nuts, fish)

Animal allergy

Hay fever

Virus infection/UTRIs

Drugs eg NSAIDS (prescribed or over the counter)

Exercise

Other, please specify \_\_\_\_\_

#### 5.3.1.1.1 Atypical features surrounding this attack to suggest anaphylaxis: *(tick all that apply)*

Sudden death  Stridor  Urticaria

Angioedema  History of food allergy resulting in anaphylaxis

Other, please specify \_\_\_\_\_

### 5.3.2 How many puffs of a rescue inhaler patient took in the 24 hours before this attack:

\_\_ puffs

Not known

### 5.3.3 Patient implemented their Personal Asthma Action Plan (PAAP):

Yes

No

Did not have a plan

Not known

## SECTION 5.4: TIMINGS OF GETTING MEDICAL HELP

### 5.4.1 What medical assistance was called for? *(tick all that apply)*

Ambulance

Called GP, advised to go to hospital

Called NHS Direct/NHS 24

Went to GP surgery

Called GP, but no appointment issued

Teacher

School nurse

Other, please specify \_\_\_\_\_

Not known

#### 5.4.1.1 If help was called, time:

\_\_:\_\_ (24-h clock)

Not recorded

### 5.4.2 Patient taken to hospital:

Yes → [Go to 5.4.2.1](#)  No → [Go to 5.4.3](#)  Not known → [Go to 5.4.3](#)

#### 5.4.2.1 If yes, route of referral to hospital:

999 ambulance service

Minor injury unit, please specify \_\_\_\_\_

Other hospital, please specify \_\_\_\_\_

Self/parental referral

Telephone advice – NHS Direct

GP assessment unit

GP surgery

Not known

Other, please specify \_\_\_\_\_

#### 5.4.2.2 Time of arrival to hospital:

\_\_:\_\_ (24-h clock)

Not recorded

**5.4.2.3 Mode of arrival to hospital:**

- |  |  |
|--|--|
| <input type="checkbox"/> Road ambulance    | <input type="checkbox"/> Public transport            |
| <input type="checkbox"/> Private transport | <input type="checkbox"/> On foot                     |
| <input type="checkbox"/> Taxi              | <input type="checkbox"/> Other, please specify _____ |

**5.4.3 Date and time first seen by health professional after onset of symptoms:**

- Not recorded  
 Not recorded

**5.4.4 First professional(s) to see patient after onset of symptoms: (tick all that apply)**

Not known

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Respiratory physician                  | <input type="checkbox"/> Junior hospital doctor               | <input type="checkbox"/> Nurse consultant (non-respiratory/other) |
| <input type="checkbox"/> General physician                      | <input type="checkbox"/> GP                                   | <input type="checkbox"/> Respiratory nurse                        |
| <input type="checkbox"/> Respiratory paediatrician              | <input type="checkbox"/> GP (wSI respiratory)                 | <input type="checkbox"/> Respiratory nurse (secondary care)       |
| <input type="checkbox"/> General paediatrician                  | <input type="checkbox"/> Practice nurse                       | <input type="checkbox"/> Paramedic                                |
| <input type="checkbox"/> Specialist registrar (respiratory)     | <input type="checkbox"/> Practice nurse (with asthma diploma) | <input type="checkbox"/> A&E consultant                           |
| <input type="checkbox"/> Specialist registrar (not respiratory) | <input type="checkbox"/> Nurse consultant (respiratory)       | <input type="checkbox"/> Other, please specify _____              |

**SECTION 5.5: CLASSIFICATION OF THIS ATTACK**

**5.5.1 In the records the attack was originally classified as (select one only):**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Near fatal (as defined in the BTS/SIGN Guidelines)       | <input type="checkbox"/> Brittle (Type 1: wide PEF variability (>40% diurnal variation for >50% of the time over a period of >150 days) despite intense therapy. Type 2: sudden severe attacks on a background of apparently well-controlled asthma) (BTS/SIGN definition) | <input type="checkbox"/> Moderate exacerbation                   |
| <input type="checkbox"/> Life threatening (as defined in the BTS/SIGN Guidelines) |  | <input type="checkbox"/> Mild exacerbation                       |
| <input type="checkbox"/> Acute severe (as defined in the BTS/SIGN Guidelines)     |  | <input type="checkbox"/> No data/not recorded in medical records |

**SECTION 5.6: MANAGEMENT OF ATTACK ASSESSMENT**

Please complete this section in as much details as possible. (For the times the patient was assessed, please detail the first four and the final assessments from the start of this patient's assessments until the last known assessment. Please provide copies of any reports (eg SEAs, SULs, audit reports))

Tick which apply	<input type="checkbox"/> Initial treatment	<input type="checkbox"/> Reassessment (1)	<input type="checkbox"/> Reassessment (2)	<input type="checkbox"/> Reassessment (3)	<input type="checkbox"/> Final assessment
<b>5.6.1 Dates/times (DD/MM/YY) (24-h clock)</b>	Date __/__/____ Time __:____ <input type="checkbox"/> Not known	Date __/__/____ Time __:____ <input type="checkbox"/> Not known	Date __/__/____ Time __:____ <input type="checkbox"/> Not known	Date __/__/____ Time __:____ <input type="checkbox"/> Not known	Date __/__/____ Time __:____ <input type="checkbox"/> Not known
<b>5.6.2 Confusion</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known
<b>5.6.3 Level of consciousness</b>	GCS scale __ (1–15) <input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Semi conscious <input type="checkbox"/> Unconscious <input type="checkbox"/> Not recorded	GCS scale __ (1–15) <input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Semi conscious <input type="checkbox"/> Unconscious <input type="checkbox"/> Not recorded	GCS scale __ (1–15) <input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Semi conscious <input type="checkbox"/> Unconscious <input type="checkbox"/> Not recorded	GCS scale __ (1–15) <input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Semi conscious <input type="checkbox"/> Unconscious <input type="checkbox"/> Not recorded	GCS scale __ (1–15) <input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Semi conscious <input type="checkbox"/> Unconscious <input type="checkbox"/> Not recorded
<b>5.6.4 Exhaustion</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known

<b>5.6.5 Speech</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Short sentences <input type="checkbox"/> Single words <input type="checkbox"/> Unable to talk <input type="checkbox"/> Not recorded	<input type="checkbox"/> Normal <input type="checkbox"/> Short sentences <input type="checkbox"/> Single words <input type="checkbox"/> Unable to talk <input type="checkbox"/> Not recorded	<input type="checkbox"/> Normal <input type="checkbox"/> Short sentences <input type="checkbox"/> Single words <input type="checkbox"/> Unable to talk <input type="checkbox"/> Not recorded	<input type="checkbox"/> Normal <input type="checkbox"/> Short sentences <input type="checkbox"/> Single words <input type="checkbox"/> Unable to talk <input type="checkbox"/> Not recorded	<input type="checkbox"/> Normal <input type="checkbox"/> Short sentences <input type="checkbox"/> Single words <input type="checkbox"/> Unable to talk <input type="checkbox"/> Not recorded
<b>5.6.6 Signs</b>					
	<b>Initial treatment</b>	<b>Reassessment (1)</b>	<b>Reassessment (2)</b>	<b>Reassessment (3)</b>	<b>Final assessment</b>
<b>5.6.6.1 Pulse rate</b>	___/min <input type="checkbox"/> Not known	___/min <input type="checkbox"/> Not known	___/min <input type="checkbox"/> Not known	___/min <input type="checkbox"/> Not known	___/min <input type="checkbox"/> Not known
<b>5.6.6.2 Respiratory rate</b>	___/min <input type="checkbox"/> Not known	___/min <input type="checkbox"/> Not known	___/min <input type="checkbox"/> Not known	___/min <input type="checkbox"/> Not known	___/min <input type="checkbox"/> Not known
<b>5.6.6.3 PEF</b>	___l/min ___% best <input type="checkbox"/> Not known	___l/min ___% best <input type="checkbox"/> Not known	___l/min ___% best <input type="checkbox"/> Not known	___l/min ___% best <input type="checkbox"/> Not known	___l/min ___% best <input type="checkbox"/> Not known
<b>5.6.6.4 SpO<sub>2</sub> Pulse oximetry</b>	___% <input type="checkbox"/> Not known	___% <input type="checkbox"/> Not known	___% <input type="checkbox"/> Not known	___% <input type="checkbox"/> Not known	___% <input type="checkbox"/> Not known
<b>5.6.6.5 PaO<sub>2</sub></b>	___kPa <input type="checkbox"/> Not known	___kPa <input type="checkbox"/> Not known	___kPa <input type="checkbox"/> Not known	___kPa <input type="checkbox"/> Not known	___kPa <input type="checkbox"/> Not known
<b>5.6.6.6 PaCO<sub>2</sub></b>	___kPa <input type="checkbox"/> Not known	___kPa <input type="checkbox"/> Not known	___kPa <input type="checkbox"/> Not known	___kPa <input type="checkbox"/> Not known	___kPa <input type="checkbox"/> Not known
<b>5.6.6.7 Serum potassium</b>	___mmol/l <input type="checkbox"/> Not known	___mmol/l <input type="checkbox"/> Not known	___mmol/l <input type="checkbox"/> Not known	___mmol/l <input type="checkbox"/> Not known	___mmol/l <input type="checkbox"/> Not known
<b>5.6.6.8 pH</b>	___ <input type="checkbox"/> Not known	___ <input type="checkbox"/> Not known	___ <input type="checkbox"/> Not known	___ <input type="checkbox"/> Not known	___ <input type="checkbox"/> Not known
<b>5.6.6.9 Blood pressure</b>	___Syst/ ___Diast <input type="checkbox"/> Not known	___Syst/ ___Diast <input type="checkbox"/> Not known	___Syst/ ___Diast <input type="checkbox"/> Not known	___Syst/ ___Diast <input type="checkbox"/> Not known	___Syst/ ___Diast <input type="checkbox"/> Not known
<b>5.6.6.10 Spirometry done</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known
<b>5.6.6.10.1 If spirometry was done, what was the FEV% predicted?</b>	___% Pred. <input type="checkbox"/> Not known	___% Pred. <input type="checkbox"/> Not known	___% Pred. <input type="checkbox"/> Not known	___% Pred. <input type="checkbox"/> Not known	___% Pred. <input type="checkbox"/> Not known
<b>5.6.6.11 Chest X-ray</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known
<b>5.6.6.11.1 If yes, describe:</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Consolidation <input type="checkbox"/> Lobar collapse <input type="checkbox"/> Other Specify _____	<input type="checkbox"/> Normal <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Consolidation <input type="checkbox"/> Lobar collapse <input type="checkbox"/> Other Specify _____	<input type="checkbox"/> Normal <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Consolidation <input type="checkbox"/> Lobar collapse <input type="checkbox"/> Other Specify _____	<input type="checkbox"/> Normal <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Consolidation <input type="checkbox"/> Lobar collapse <input type="checkbox"/> Other Specify _____	<input type="checkbox"/> Normal <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Consolidation <input type="checkbox"/> Lobar collapse <input type="checkbox"/> Other Specify _____

5.6.6.12 Examination					
	Initial treatment	Reassessment (1)	Reassessment (2)	Reassessment (3)	Final assessment
<b>5.6.6.12.1 Wheezing</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known
<b>5.6.6.12.2 Cyanosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known
<b>5.6.6.12.3 Pathological arrhythmia</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known
<b>5.6.6.12.4 Use of accessory muscles</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known
<b>5.6.6.12.5 Normal chest examination</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known
<b>5.6.6.12.6 Silent chest</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known

## SECTION 5.7: MANAGEMENT OF ATTACK (DRUGS)

(Please provide copies of any reports (eg SEAs, SUIs, audit reports))

**5.7.1 Patient was administered a short-acting beta agonist bronchodilator:**  Yes → Go to 5.7.1.1  No → Go to 5.7.2  Not known → Go to 5.7.2

**5.7.1.1 If yes, first dose at:** \_\_\_/\_\_\_/\_\_\_ (DD/MM/YYYY)  
 \_\_\_:\_\_\_ (24-h clock)  Not recorded

**5.7.1.2 Please state the route of administration:**  
*(tick all that apply)*

Spacer inhaler plus pMDI  Nebuliser (air driven)  
 Nebuliser (oxygen driven)  Dry powder inhalers (DPI)  
 pMDI alone (\*pMDI=pressurised metered-dose inhaler)

**5.7.1.3 Drug name and the dose:**

Salbutamol (eg Ventolin)  Terbutaline (eg Bricanyl)  
 Other, please specify \_\_\_\_\_  
 Dose: \_\_\_\_\_ µg  Not known

**5.7.1.4 Was this continuous?**  Yes  No  Not known

**5.7.2 Patient administered an antimuscarinic bronchodilator, eg ipratropium bromide (Atrovent):**  Yes → Go to 5.7.2.1  No → Go to 5.7.3  Not known → Go to 5.7.3

**5.7.2.1 If yes, first dose at:** \_\_\_/\_\_\_/\_\_\_ (DD/MM/YYYY)  
 \_\_\_:\_\_\_ (24-h clock)  Not known

**5.7.2.2 Please state the route of administration:**  
*(tick all that apply)*

Spacer inhaler plus pMDI  Nebuliser (air driven)  
 Nebuliser (oxygen driven)  Dry powder inhalers (DPI)  
 pMDI alone (\*pMDI=pressurised metered-dose inhaler)

**5.7.2.3 Drug name and the dose:**  Ipratropium bromide  
Dose: \_\_\_\_\_ µg/mg \_\_\_\_\_

**5.7.3 Patient administered systemic steroids (including oral or intravenous):**  Yes → [Go to 5.7.3.1](#)  No → [Go to 5.7.4](#)  Not known → [Go to 5.7.4](#)

**5.7.3.1 If yes, first dose at:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)  
\_\_\_\_:\_\_\_\_ (24-h clock)  Not recorded

**5.7.3.2 Please state the route of administration:**  
*(tick all that apply)*  Oral tablets  Systemic injection  
 Dispersible tablets  Not known

**5.7.3.3 Drug name and the dose:**  
Drug: \_\_\_\_\_  
Dose: \_\_\_\_\_

**5.7.4 Patient administered oxygen:**  Yes → [Go to 5.7.4.1](#)  No → [Go to 5.7.5](#)  Not known → [Go to 5.7.5](#)

**5.7.4.1 If yes, first dose at:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)  
\_\_\_\_:\_\_\_\_ (24-h clock)  Not recorded

**5.7.4.2 Flow rate:** \_\_\_\_\_ l/min  Not known

**5.7.4.3 Concentration:** \_\_\_\_\_%  Not known

**5.7.4.4 Device:**  Nasal speculum  Mask  
Type of mask: \_\_\_\_\_

**5.7.5 Patient administered adrenaline:**  Yes → [Go to 5.7.5.1](#)  No → [Go to 5.7.6](#)  Not known → [Go to 5.7.6](#)

**5.7.5.1 If yes, first dose at:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)  
\_\_\_\_:\_\_\_\_ (24-h clock)  Not recorded

**5.7.5.2 Dose and route of administration:**

Auto-injector (by health professional or carer) Dose: \_\_\_\_\_  Intravenous Dose: \_\_\_\_\_  
 Intramuscular Dose: \_\_\_\_\_  Self-administered auto-injector Dose: \_\_\_\_\_  
 Other, please specify \_\_\_\_\_ Dose: \_\_\_\_\_

**5.7.6 Patient administered intravenous aminophylline?**  Yes → [Go to 5.7.6.1](#)  No → [Go to 5.7.7](#)  Not known → [Go to 5.7.7](#)

**5.7.6.1 If yes, first dose at:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)  
\_\_\_\_:\_\_\_\_ (24-h clock)  Not recorded

**5.7.7 Patient administered a leukotriene receptor antagonist:**  Yes → [Go to 5.7.7.1](#)  No → [Go to 5.7.8](#)  Not known → [Go to 5.7.8](#)

**5.7.7.1 If yes, first dose at:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)  
\_\_\_\_:\_\_\_\_ (24-h clock)  Not recorded

**5.7.8 Patient administered any intravenous fluids:**  Yes → [Go to 5.7.8.1](#)  No → [Go to 5.7.9](#)  Not known → [Go to 5.7.9](#)

**5.7.8.1 If yes, first dose at:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)  
\_\_\_\_:\_\_\_\_ (24-h clock)  Not recorded

**5.7.9 Patient administered magnesium (Mg):**  Yes → [Go to 5.7.9.1](#)  No → [Go to 5.10](#)  Not known → [Go to 5.10](#)

**5.7.9.1 If yes, first dose at:** / /  (DD/MM/YYYY)  
:  (24-h clock)  Not recorded

**5.7.9.2 Was the Mg repeated?**  Yes  No  Not known

**5.7.10 Assisted ventilation initiated:**  Yes → [Go to 5.7.10.1](#)  No → [Go to 5.8](#)  Not known → [Go to 5.8](#)

**5.7.10.1 If yes, was this:**  NIV  CPAP  Intubation  Not known

**5.7.10.2 Was the patient mechanically ventilated?**  Yes  No  Not known

### SECTION 5.8: DISPOSAL

Admitted to hospital:  Yes → [Specify date](#)  No / /  (DD/MM/YYYY)

Discharged from A&E:  Yes → [Specify date](#)  No / /  (DD/MM/YYYY)

Discharged from medical ward (including medical admissions unit):  Yes → [Specify date](#)  No / /  (DD/MM/YYYY)

Admitted to ITU:  Yes → [Specify date](#)  No / /  (DD/MM/YYYY)

Admitted to ITC:  Yes → [Specify date](#)  No / /  (DD/MM/YYYY)

Required mechanical ventilation:  Yes → [Specify date](#)  No / /  (DD/MM/YYYY)

Date discharged home: / /  (DD/MM/YYYY) / /  (DD/MM/YYYY)

Length of stay in hospital (days):  days

### SECTION 5.9: FOLLOW UP OF THIS ATTACK

**5.9.1 Evidence in the record that this patient's inhaler technique was checked during or after treatment of this attack:**  Yes  No  Not known

**5.9.2 Evidence in the record of a structured management plan following treatment of this attack: (education, medication, follow-up and safety netting advice)**  Yes  No  Not known

**5.9.3 Evidence of issuing a new or updated written asthma action plan for this patient following treatment of this attack:**  Yes  No  Not known

**5.9.4 Patient was prescribed systematic steroids for ongoing short course of treatment following this attack:**  Yes  No  Not known

**5.9.4.1 If yes, for how long?**  <3 days  Until better  
 <5 days  Not known  
 Until review

**5.9.5 Patient seen for follow up after this attack:**  Yes → [Go to 5.9.5.1](#)  No → [Go to 5.9.6](#)  Not known → [Go to 5.9.6](#)

**5.9.5.1 If yes, within what time period?**  <48 hours  >1 week  
 <72 hours  Not known  
 <1 week

**5.9.6 What health professional saw them for the follow-up?** *(tick all that apply)*

Not known

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Respiratory physician                  | <input type="checkbox"/> Junior hospital doctor               | <input type="checkbox"/> Nurse consultant (non-respiratory/other) |
| <input type="checkbox"/> General physician                      | <input type="checkbox"/> GP                                   | <input type="checkbox"/> Respiratory nurse                        |
| <input type="checkbox"/> Respiratory paediatrician              | <input type="checkbox"/> GP (GPwSI respiratory)               | <input type="checkbox"/> Respiratory nurse (secondary care)       |
| <input type="checkbox"/> General paediatrician                  | <input type="checkbox"/> Practice nurse                       | <input type="checkbox"/> Paramedic                                |
| <input type="checkbox"/> Specialist registrar (respiratory)     | <input type="checkbox"/> Practice nurse (with asthma diploma) | <input type="checkbox"/> A&E consultant                           |
| <input type="checkbox"/> Specialist registrar (not respiratory) | <input type="checkbox"/> Nurse consultant (respiratory)       | <input type="checkbox"/> Other, please specify _____              |

**FOR THOSE PATIENTS TREATED ELSEWHERE – IN HOSPITAL (INPATIENT OR A&E OR URGENT CARE CENTRE):**

**5.9.7 Practice was notified that the patient had had an asthma attack:**

- |   |  |
|---|--|
| <input type="checkbox"/> <48 hours after the attack | <input type="checkbox"/> >5 days after the attack  |
| <input type="checkbox"/> 2–5 days after the attack  | <input type="checkbox"/> No record of notification |

**5.9.8 If a letter was received from the hospital – detailed:** *(tick all that apply)*

- |  |  |
|--|--|
| <input type="checkbox"/> Treatment given         | <input type="checkbox"/> Any safety netting advice   |
| <input type="checkbox"/> Advice given to patient | <input type="checkbox"/> Other, please specify _____ |
| <input type="checkbox"/> Follow-up advice        |  |

**5.9.9 If a letter was received from the hospital/urgent care centre, did this detail the post-treatment PEF of the patient?**

- Yes → [Go to 5.9.9.1](#)     No     Not known

**5.9.9.1 If yes, what was it?** \_\_\_\_\_ l/min

**ADDITIONAL SPACE FOR FURTHER INFORMATION** *(please indicate question number you are referring to)*

\_\_\_\_\_

**PLEASE PHOTOCOPY THIS FORM AND KEEP A COPY FOR YOUR RECORDS BEFORE RETURNING TO THE NRAD OFFICE AT THE RCP. POSTAL/EMAIL DETAILS CAN BE FOUND AT THE FRONT OF THIS FORM.**