我的氣喘護理計畫 CHINESE

Medical Record #

醫務人員姓名：_____

醫務人員電話號碼：_____ 填寫人：_____ 日期：_____

控制藥物	服用數量	服用次數	其他說明
		____ 次/每天 **每天服用！**	❑ 服藥後漱口
		____ 次/每天 **每天服用！**	
		____ 次/每天 **每天服用！**	
		____ 次/每天 **每天服用！**	

快速舒緩藥物	服用數量	服用次數	其他說明
❑ Albuterol (ProAir、Ventolin、Proventil) ❑ Levalbuterol (Xopenex)	❑ 吸藥兩次 ❑ 吸藥四次 ❑ 1 次噴霧器治療	需要時才服用 （請參閱以下指示 — 於黃區開始時，或運動前使用）	注意：如果您每週需要服用本藥物兩天以上，請電洽醫師，考慮增加控制藥物的服用劑量，並討論您的治療計畫。

右列情況下的特殊指示： ● *病情穩定* ○ *病情惡化* ● *病情緊急*

病情*穩定*。

- 日間或夜間無咳嗽、喘鳴聲、胸悶或呼吸急速情況發生。
- 可從事正常活動

尖峰呼氣流速（適用於 5 歲以上）：
為 _____ 以上。（個人最佳紀錄的 80% 以上）

個人最佳尖峰呼氣流速（適用於 5 歲以上）：_____

下列的每日例行工作可*避免*氣喘症狀發作：

- ☐ 每天服用上述控制藥物。
- ☐ 運動前，吸入_____次數_____
- ☐ 避免會讓我氣喘症狀惡化的情況。（請見表格背面。）

病情*惡化*。

- 咳嗽、喘鳴聲、胸悶、呼吸急速，或
- 因氣喘發作而在夜間醒來，或
- 可從事一些（但並非全部）正常活動

尖峰呼氣流速（適用於 5 歲以上）：
_____ 至 _____（個人最佳紀錄的 50 至 79%）

警戒範圍。每天持續服用控制藥物，並：

- ☐ 吸入____次數快速舒緩藥物或進行____次噴霧器治療。如果我在 20-30 分鐘內未回到*綠區*，必須再多吸藥 ____ 次或進行 ____ 次噴霧器治療。如果我在 1 小時內未回到*綠區*，我應該：
- ☐ 增加_____
- ☐ 新增_____
- ☐ 致電_____
- ☐ 視需要每 4 小時服用快速舒緩藥物。如果 _____ 天後仍無改善，請電洽服務提供者。

病情緊急

- 呼吸非常急速，或
- 快速舒緩藥物無效，或
- 無法從事正常活動，或
- 症狀處於黃區 24 小時後仍無改善或惡化。

尖峰呼氣流速（適用於 5 歲以上）：
少於 _____（個人最佳紀錄的 50%）

病情緊急！就醫治療！

- ☐ 服用快速舒緩藥物：每____分鐘吸入____次數，並即刻送醫。
- ☐ 服用 _____
- ☐ 致電 _____

危險！盡速就醫！ 如因呼吸急速而難以步行或說話，或有嘴唇或指甲發灰或發藍現象，請撥 911 求救。病患者如為兒童，呼吸時，如頸周圍的皮膚和肋骨縮緊下陷，或病患者無法正常回應，請撥 911 求救。

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ❑ Yes ❑ No self administer asthma medications: ❑ Yes ❑ No (This authorization is for a maximum of one year from signature date.)

_____ _____
Healthcare Provider Signature Date

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

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Child Asthma Plan

This Care Plan Authorized by:

Does this child requires a 3 day Emergency supply of medication at child care ? ☐ Yes ☐ No
If yes, please complete the 3 Day Emergency Medication Supply form

Parent/Guardian's Signature	Date
Health Care Provider's Signature	Date
Health Care Provider's Name (Print):	
Health Care Provider's Agency:	

Emergency Contact *Information*

Parent/Guardian #1	Phone #1	Phone #2
Parent/Guardian #2	Phone #1	Phone #2
Emergency Contact #1	Phone #1	Phone #2
Emergency Contact #2	Phone #1	Phone #2

Special Instructions:

Staff Training Information

Staff Name	Trainer (parent or guardian)	Date

*Please note: We recommend reviewing this plan monthly to assure the information is current. A new plan must be completed when changes occur or annually, whichever is sooner.

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›.