ASTHMA

I. **Exclusion Criteria**

A. New EKG change (except sinus tachycardia)
B. RR >40
C. Impending respiratory fatigue/failure
D. Evidence of CHF
E. Inability to perform spirometry
F. ABG’s (if obtained) 7.30 < pH > 7.50, p02 < 70, pc02 >45
G. Pulse oxymeter < 90% on room air
H. Bronchospasm due to epiglottitis, aspiration, FB
I. Temp > 101F

II. **OBS Interventions**

A. Serial exams including vital signs every 1-4 hours
B. Pulse oximeter monitoring
C. Supplement oxygen
D. Repeat ABG’s if indicated
E. Hydration
F. Steroids, bronchodilator
G. Peak flow

III. **Disposition Criteria**

**HOME**

A. Major resolution of SOB
B. Resolution of accessory muscle usage
C. Resolution of most wheezing

**HOSPITAL**

A. Deterioration of condition
B. PEFR deterioration to < 20% expected
C. RR >35
D. EKG abnormalities
E. Pulse oxymeter < 90% on room air x 30 min.

IV. **Time Frame**

A. 8-12 hours for observation and treatment

**NOT A PART OF THE MEDICAL RECORD**
DIAGNOSIS: ASTHMA

1. Admit to Emergency Department Observation Unit
2. Initial Emergency Department Physician: _______________________________ Time Contacted: __________________
3. Private Physician: ___________________________ Time Contacted: __________________
4. Consult: ___________________________________________________________
5. Condition: ___ Stable ___ Serious
6. Copies of Emergency Department H&P on chart
7. Allergies: __________________________________________________________
8. Routine Vital Signs
9. ST segment - continuous monitoring, ____ continuous pulse oximetry
10. Activity: ___ up ad lib ___ Other: ________________________________
11. Diet: ___ Clear liquid, advance as tolerated ___ Regular
   ___ Oral rehydration solution (pedalyte) ___ Other: __________________
12. IV Fluids: ___ D5½NS + 20 meq KCl/1000ml at ___ml/hour
   ___ NS at ___ml/hour
   ___ Other: __________________________
13. Medications:
   ___ Tylenol 1 gram po every 6 hours prn pain or fever > 101°
   ___ Tylenol 10mg/kg oral/rectal every 6 hours prn fever > 101°
   ___ Motrin 800 mg po every 6 hours prn pain
   ___ Ultram 50 mg po every 6 hours prn pain
   ___ Maalox 30 cc po every 4 hours prn indigestion
   ___ Phenergan
       ___ 25mg IV every 6 hours prn nausea/vomiting
       ___ 12.5mg IV every 6 hours prn nausea/vomiting
   ___ Zofran
       ___ 4mg IV every 4 hours prn nausea/vomiting
       ___ 0.15mg/kg IV every 4 hours prn nausea/vomiting
   ___ Rocephin 1 gram IV every 24 hours plus Zithromax 500mg IV every day
   ___ Levaquin 500mg IV every 24 hours (only if allergic to cephalosporins)
   ___ Solumedrol 80 mg IV q 8 hours
   ___ Prednisone ___mg po q day
   ___ Albuterol 1 ud q 3 hours and prn OR ______ Albuterol ___ud q ___ hours and prn
   ___ Atrovent 1 ud q 6 hours and prn
14. Re-evaluate for discharge every 3 hours
15. Peak Flow before each treatment
16. Oxygen ___L NC or ____% VM to keep O2 sat above 94%

____________________________________________  ________________________
Emergency Department Physician Signature   Date/Time
Please date and sign each entry.

<table>
<thead>
<tr>
<th>DATE:</th>
<th>TIME:</th>
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<tbody>
<tr>
<td>PROTOCOL: ASTHMA</td>
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<tr>
<td>RELEVANT HISTORY/PHYSICAL FINDINGS:</td>
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<tr>
<td>OBSERVATION INTERVENTIONS:</td>
<td></td>
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<tr>
<td>IV Hydration as indicated</td>
<td>Oxygen as needed</td>
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<tr>
<td>Serial Exams and Vital Signs</td>
<td>Pulse Oximetry</td>
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<tr>
<td>Bronchodilators, Steroids</td>
<td>Repeat ABG’s as indicated</td>
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<tr>
<td>GOALS OF OBSERVATION PERIOD:</td>
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<td>HOW OFTEN WILL PATIENT BE EVALUATED BY PHYSICIAN:</td>
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<tr>
<td>MORNING PLAN</td>
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<tr>
<td>PRIMARY PHYSICIAN CONTACTED:</td>
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<tr>
<td>YES</td>
<td>NAME:</td>
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<td>NO</td>
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ATTENDING SIGNATURE / DATE
EMERGENCY DEPARTMENT
OBSERVATION UNIT

ASTHMA
DISCHARGE NOTE

DATE:

TIME:

PRESENTING COMPLAINT:

OBSERVATION COURSE:

___ Serial Exams, Vital Signs, Pulse oximetry
___ Bronchodilators
___ Steroids
___ IV Hydration
___ Tolerating PO
___ Peak Flow with improvement

PHYSICAL EXAM:

FINAL DIAGNOSIS:

DISPOSITION: ___ Home ___ Admission

DISCHARGE INSTRUCTION GIVEN: ___ Yes ___ No

PRIMARY PHYSICIAN CONTACTED: ___ Yes ___ No

NAME: _____________________________

FOLLOW UP:

ATTENDING SIGNATURE / DATE