



## **MAP Home Visting Referrals**

### **Outcomes Report Form**

**Grantee Name(s):**

**County:**

**Return to:**

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**Questions:**

1. How many students in your did you identify as having a current asthma diagnosis?
2. How many students were assessed for asthma control (i.e. Asthma Control Test and ED visit in the last year)?
3. How many students were identified as having uncontrolled asthma?
4. Describe how you were able to identify and contact students with asthma. What were the successes and challenges that you experienced in recruiting participants?
  
5. For students with uncontrolled asthma, how were parents contacted and informed about the MAP?

6. What asthma resources did you give to all screened students with asthma?
  
  
  
  
  
  
  
  
  
  
6. Were resources from the Montana Asthma Control program useful? Y/N
7. Was the MAP nurse in your area contacted? Y/N
8. Was follow-up conducted with families referred to the MAP? Y/N
9. How many students were enrolled in the MAP?
10. For families that chose not to enroll their child in the MAP, what reasons did they give for not doing so?
  
  
  
  
  
  
  
  
  
  
11. Would you recommend this particular project for other school nurses or asthma educators?  
Why or why not?