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| **Community pharmacy referral form** | **Date** |  |

| **To (GP practice name)** |  |
| --- | --- |

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| --- | --- | --- | --- | --- |
| **Patient’s name** |  | | | |
| **Patient’s address** |  | | | |
| **Patient’s DOB** |  | **NHS number** (where known) |  | |
|  |  |  |  | |
| This patient with asthma has been identified as (tick all that apply): | | | | |
| * Having been prescribed more than 6 short-acting bronchodilator inhalers without any corticosteroid inhaler within a 6-month period. | | | |  |
| * Not having been prescribed a spacer device. \* | | | |  |
| * Not having a Personalised Asthma Action Plan. \*   \*The patient is aged 5-15 years. | | | |  |
| Consent has been obtained to notify you of this, as there may be a need for their asthma management to be reviewed. | | | | |
| Additional comments (e.g. actions taken following intervention such as inhaler technique check and/or Medicines Use Review) | | | | |

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| **Pharmacy name** |  |
| **Address** |  |
| **Telephone** |  |

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