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

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

|  |  |
| --- | --- |
| **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)      |

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

**CONFIDENTIAL**