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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): | | | | |
| * Not having been prescribed a spacer device for use with their pMDI (the patient is aged 5-15 years). | | | |  |
| * Not having a Personalised Asthma Action Plan. | | | |  |
| 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). | | | | |

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

**CONFIDENTIAL**