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

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

|  |  |
| --- | --- |
| **Patient’s name** |  |
| **Patient’s address** |  |
| **Patient’s DOB** |  | **NHS number** (where known) |  |
| This patient has been identified being prescribed a long-acting beta agonist without using an inhaled corticosteroid. The patient has agreed that you may be notified of this, as there may be a need for their therapy 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** |  |

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