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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** |       |

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