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):			
• 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).			

Pharmacy name	
Address	
Telephone	

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