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 press and breathe pressurised MDI (the patient is aged 5-15 years).	☐
• Not having a Personalised Asthma Action Plan.	☐
• Having been prescribed 3 or more short-acting bronchodilator inhalers without any corticosteroid inhaler within a six-month period.	☐
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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