ASTHMA CLINIC

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The Asthma Team
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DATE: Patient Name DOB PHN # Phone number	Referring MD Address Phone Fax MSP #

□ **URGENT (reason):**
□ Routine
□ Interpreter required Language spoken:

REASON FOR REFERRAL

Where would you like the patient to be assessed?
□ **Asthma Clinic** (patient to be seen by physician or nurse practitioner + asthma educator)
□ **Asthma Education Clinic** (patient to be seen by asthma educator only)

Reason:

- ☐ Diagnosis
- ☐ Persistent symptoms despite adequate medication
- ☐ Frequent and/or severe exacerbations despite adequate medication
- ☐ Family requires education about asthma
- ☐ Other

Specific clinical question/Expectations of the consultation:

Age when asthma was diagnosed:

RELEVANT PATIENT INFORMATION

THIS INFORMATION IS **CRITICAL** FOR YOUR PATIENT TO BE TRIAGED APPROPRIATELY

In the past 12 months: Number of courses of oral corticosteroids ___ Number of ER visits ___ Number of hospitalizations for asthma ___	ANY past ICU admissions _____ Other medical conditions _____ Psychosocial concerns _____

Current asthma medications (drug, dose, # inhalations & frequency)	In use since:
1. 2 3. 4.	

If inhaled corticosteroids are prescribed, is the use continuous or intermittent? (circle one)
Past medications for asthma:

Relevant investigations, procedures, consultations (please attach results):

- ☐ Pulmonary function test ☐ Allergy consultation
- ☐ Chest x-ray ☐ Other

Other specialists involved in patient's care:

Please fax referral to (604) 875-3653

Revised October 2013