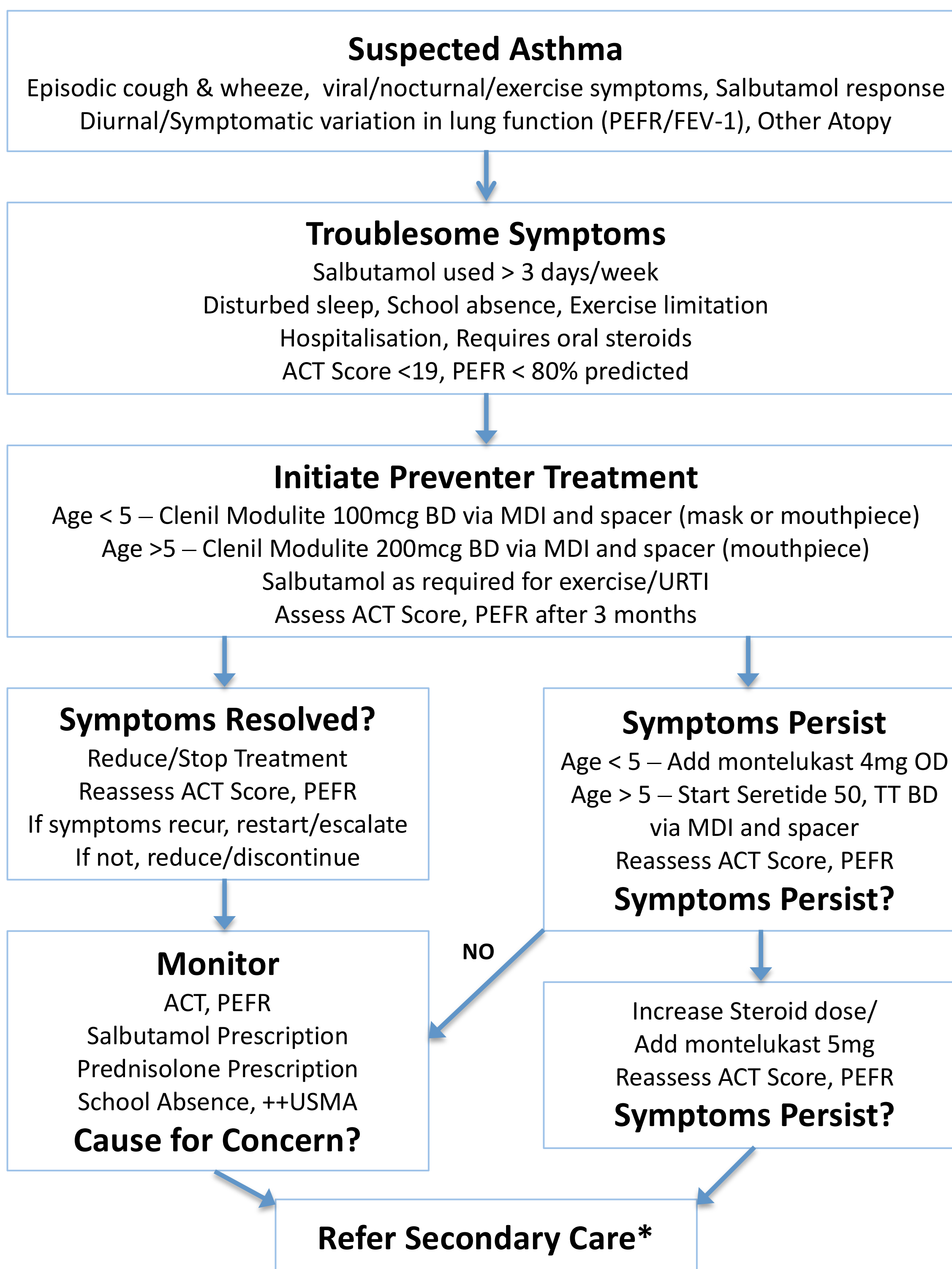
Chronic Management – Primary Care



General and Respiratory Paediatrics
CHINEDU "DR CHIN" NWOKORO, MB BCHIR MRCPCH
CHILD CHEST CLINIC
www.childchestclinic.com
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Asthma Clinic Referral

Patient Details:
Name:_________________________DOB:_________
Address:_____________________________________
Phone:_________________ID#:__________________
School:_______________________________________

Referrer Details:
Name:_____________________________________
Practice/Trust:______________________________
NHS.net Email:______________________________
Contact Number:____________________________

Reason for referral (please tick):

Uncertain diagnosis	☐	Repeated wheezing ED/LAS attendance (≥2/year)	☐
Recent hospital admission	☐	On >400mcg/day of beclomethasone or equivalent	☐
Salbutamol Overuse (>1/month)	☐	Repeated oral steroid use (2 or more in a year)	☐
Recent PCCU/IV asthma therapy	☐	Associated food allergies/history of anaphylaxis	☐

Asthma Medications (comment on response below):

Medication (e.g. Clenil 100)	Dose	Unit	Freq	Route/Formulation (incl spacer type)

Asthma control:

ACT score:______ (<19 = poor control) ☐
Previous PICU/HDU (No in last yr)___ ☐
Multiple courses of oral steroids: ☐
NRAD Risk Stratification - high?: ☐

Brief History: (include triggers, other medications, psychosocial, investigations, diagnostic doubt, comorbidities)

Please note this is for routine referrals if your referral is urgent please contact the paediatrician on call to discuss