

Asthma Fax

Pharmacy: _____ Phone: _____ Date: _____

Attention: _____ Fax: _____

Pharmacist Evaluation

Patient: _____

DOB: _____ **Phone** _____

Asthma Control Test Score _____
(less than 19 indicates impairment)

Beta-agonist use seems appropriate (two or less days per week and less than one MDI per month)

Beta-agonist use seems excessive

Patient demonstrated proper inhaler technique for _____.

Patient demonstrated improper inhaler technique for _____.

Proper technique was reviewed/taught

Adherence to controller medication

Appropriate Inappropriate

Patient is aware of an asthma action plan

Plan was reviewed/taught.

Patient is not aware of asthma action plan

Based on patient's current symptoms, according to the 2007 NIH Guidelines, their asthma is:

- | | |
|---|--|
| <input type="checkbox"/> Well controlled | <input type="checkbox"/> Intermittent |
| <input type="checkbox"/> Not well controlled | <input type="checkbox"/> Mild Persistent |
| <input type="checkbox"/> Very poorly controlled | <input type="checkbox"/> Moderate Persistent |
| | <input type="checkbox"/> Severe Persistent |

Please review and reply:

No changes recommended.

I recognize that the patient's poor control and high beta agonist use may be due to improper inhaler technique and/or poor adherence to controller medication(s). Patient has agreed to see physician immediately if symptoms worsen or in two weeks for follow up if symptoms do not improve following education and teaching.

Patient demonstrates good technique and is compliant but has suboptimal control. We asked them to contact your office for an appointment.

Please consider prescribing a:

Spacing device

Long-term controller regimen (e.g. an inhaled corticosteroid, leukotriene modifier).

Please consider completing an asthma action plan with patient.

RPh. Signature

RPh Name (Print)

Physician Response (optional): Please choose one of the following and fax back to:

(____) _____ - _____

I will have staff call and schedule an appointment with patient.

I will address your concerns at the patient's next scheduled visit.

Thank you for your input, but no change in therapy at this time.

Comments: _____

Physician Name (Print)

Physician Signature

Phone

