**EPUT Children’s Asthma & Allergy Service**

**ASTHMAReferral Form**

**Please return by email to:** [**epunft.caa@nhs.net**](mailto:epunft.caa@nhs.net)

Telephone: 0344 257 3955

**Referrals that do not meet our criteria or are incomplete will be rejected**

**Asthma Referral Guidance**

1. **Aged 2 to 18 years**
2. **Live within the SSO to SS9 postcode area**
3. **The Service only accepts patients over 2 years of age. If under 2 years please refer to paediatrics if you have concerns.**
4. **The patient will only be accepted if they have trialled ICS treatment at 400mcg per day or ICS/LABA 200mcgs per day** and remain uncontrolled.
5. For asthma care plans for schools and nurseries, please contact universal services, i.e. GP, school nurse, health visitors or practice nurse.
6. For routine education on use of asthma devices please refer to GP/Pharmacist.
7. **For educational resources please see Asthma + Lung UK website** [**https://www.asthmaandlung.org.uk/**](https://www.asthmaandlung.org.uk/)

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| **SECTION 1 – ASTHMA – Referrals require at least point 1 to be ticked as a minimum *(please tick all that apply)*:** | |
| 1. Children with **uncontrolled asthma** on ICS 400mcg per day or ICS/LABA 200mcgs per day. Symptoms include the following: | |
| * nocturnal symptoms |  |
| * persistent cough and wheeze |  |
| * exertional symptoms |  |
| 1. Prescribed more than **eight** short-acting Beta-agonists (SABAs) in the last 12 months in conjunction with **uncontrolled asthma** symptoms as per the list at point 1) above |  |
| 1. Two or more courses of steroids over the last 12 months in conjunction with **uncontrolled asthma** symptoms as per the list at 1) above |  |
| 1. One acute episode of exacerbation of suspected/diagnosed asthma requiring nebulisers or a course of oral steroid resulting in attendance at the Emergency Department (ED). |  |
| 1. Admitted to hospital for suspected/diagnosed asthma exacerbation |  |

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| **SECTION 2 – REASON FOR REFERRAL, HISTORY OF SYMPTOMS & CURRENT MEDICATIONS** | | | |
| Give details for referral | | | |
|  | | | |
| History of symptoms | | | |
|  | | | |
| Current Medications | | | |
| Asthma Reliever |  | Asthma Preventer & Dose |  |
| Other Medications |  | | |

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| **SECTION 3 - PATIENT DETAILS** | | | | | | | | | | | | | | | |
| NHS Number | |  | | | | Surname | | | |  | | | | | |
| First Name |  | | | | Date of Birth | | |  | | | | Gender | |  | |
| Address |  | | | | | | | | | | | Postcode | |  | |
| Parent/Carer Full Name | | |  | | | | | | Parent/Carer Contact No | | | |  | | |
| Carer consent to referral | | |  | Spoken language | | |  | | | | Interpreter required | | | |  |

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| **SECTION 4 - REFERRER’S DETAILS** | | | | | | | |
| Date of referral | |  | | Referee Name |  | | |
| Designation |  | | Service Referring | |  | Contact Number |  |