



Optimizing Chronic Disease Management

Asthma Program Referral

Royal University Hospital
Saskatoon, SK S7N 0W8
Phone: (306) 655-1054
Fax: (306) 655-6758

Client Information

Name: _____

DOB: _____ PHN: _____

Address: _____

Phone: (home) _____ (work) _____

Referring Health Care Professional: _____ PH: _____

Family Doctor: _____

History

1. Level of Asthma Severity: Mild Moderate Severe

2. Present Medications & Dosages: _____

3. Other pertinent health history: _____

4. Has your patient been on Oral Corticosteroid Therapy **within the last year?**

Yes, how often? _____ No

Admitted to hospital? Yes No

Visited the Emergency Room? Yes No

5. Does your patient have a written Action Plan? Yes No

6. Would you like the Asthma Clinic to initiate an Action Plan for your review?

Yes No

7. Patient aware of referral? Yes No

* **Has spirometry/PFT been done?** Yes No

* **Has allergy testing been done?** Yes No

Results:

Comments: (e.g. adherence)

Please book this patient's appointment at the following location:

West Winds Primary Health Center

Royal University Hospital

Fax completed form to: (306) 655-6758

