Fax Cover

TO:	FROM:
	PAGES:
FAX:	PHARMACY FAX:
PHONE:	PHARMACY PHONE:

MESSAGE:
Please forward this information to the provider listed above to include in this patient's chart.

PATIENT: DOB:

Please send a return fax to _____ with your response to the following questions:

1. Check box if this is not your patient. ☐
2. Did you find this information helpful in managing your patient's asthma? ☐ Yes ☐ No
3. What steps will be or have been taken to follow-up with your patient?
   - ☐ Our staff will contact the patient to schedule a follow-up visit.
   - ☐ The Asthma Care Fax will be included in the patient's chart for discussion at the next visit.
   - ☐ I have met with the patient for an asthma follow-up visit.
   - ☐ Other, please describe:

4. Would you like to refer this patient for a comprehensive medication review and assessment with our pharmacy as part of the Wisconsin Pharmacy Quality Collaborative (WPQC) program?
   ☐ Yes ☐ No ☐ I would like more information about WPQC

PROVIDER SIGNATURE: DATE:

Asthma Care Fax for 5 to 11 year olds

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Provider Name: _____ Date: _____ Fax: _____

Patient: _____ DOB: _____

Based on my evaluation of this patient, I have noticed excessive use of the following beta$_2$-agonist(s) _____ at a rate of _____inhaler(s) per 90 days. I have also evaluated his/her inhaler technique and adherence to prescribed controller medication regimen.

Patient's current asthma medication(s): _____

Patient Evaluation:

Inhaler/Device Technique:

- ☐ Proper
- ☐ Improper

Adherence to controller therapy:

- ☐ Appropriate
- ☐ Inappropriate

- ☐ Patient not available for evaluation – Please consider review at next visit
- ☐ Patient gets Rx's at multiple pharmacies

	Days with Symptoms	Nighttime Awakenings	Short Acting Beta-Agonist Use	Preferred Action
Very Poorly Controlled	Continuous	≥2 per week	Several times daily	Oral steroid burst Step up 1-2 steps
Not Well Controlled	> 2 per week	≥2 per month	> 2 days per week	Step up at least 1 step
Well Controlled	≤ 2 per week	≤1 per month	≤ 2 days per week	Maintain care, step down if stable ≥ 3 months

Current guidelines for asthma treatment of 5 to 11 year olds- NIH 2007

	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Preferred Therapy	SABA prn	Low-dose ICS	Low-dose ICS + LABA OR Med-dose ICS	Med-dose ICS + LABA	High-dose ICS + LABA	High-dose ICS + LABA + Oral steroid burst

* Alternative therapies and more detailed guidelines available at: http://www.nhlbi.nih.gov/guidelines/asthma/index.htm

Patient's current step in care: _____
(if known)

Patient's Child Asthma Control Test Score: _____
(if known) ≤ 19 may indicate uncontrolled asthma

Pharmacist's Recommendation

- ☐ **Based on the most recent guidelines from the National Institute of Health (NIH), I recommend a step up in asthma therapy.**
- ☐ **The patient demonstrated improper inhaler technique which may have contributed to excessive SABA use. After consultation, the patient demonstrated proper device technique. May wish to reevaluate at next visit.**
- ☐ **Based on refill history, the patient's adherence to prescribed controller therapy is suboptimal. We discussed the importance of using controller medications daily and only using rescue medications when needed.**

Comments:

Pharmacist Signature: _____

Revised: 12-21-12