EMERGENCY DEPARTMENT ASTHMA REFERRAL FORM

DATE: ______ / ______ / ______

TO: ____ **FAX:** ____________ **PH:** ____________
(Primary Care Provider or Medical Home)

FROM: ____ **FAX:** ____________ **PH:** ____________
(Emergency Department)

RE: Your patient recently visited our emergency department due to his/her asthma. The purpose of this form is to provide you with basic information about this visit. For more information, contact the hospital listed above.

Patient Information:

Patient's Name: __________________________________ **D.O.B.:** ____ / ____ / ____ **PH:** _____________

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Age: ______________ **Gender:** ☐ Male ☐ Female **Home Zip Code:** ______________

Patient History:

Does the patient have a written Asthma Action Plan? ☐ Yes ☐ No

Does the patient smoke? ☐ Yes ☐ No

Does the patient live with a smoker? ☐ Yes ☐ No

In the past 12 months, how many times did the patient visit the ED for asthma? _____ (including today's visit)

Medication(s) Used By Patient Prior To ED Visit:

Asthma "Rescue" Medication(s): ____

Asthma "Controller" Medication(s): ____

"Other" Asthma Medications(s): ____

Peak Flow Meter Reading:

Pre-Treatment: __________ Post-Treatment: __________

Asthma Control Test (ACT):

Refer to attached Asthma Control Test (ACT) for more information about this patient.

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FOR PATIENTS:

Take the Asthma Control Test™ (ACT) for people 12 yrs and older.

Know your score. Share your results with your doctor.

Step 1 Write the number of each answer in the score box provided.

Step 2 Add the score boxes for your total.

Step 3 Take the test to the doctor to talk about your score.

1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
1	2	3	4	5

2. During the past **4 weeks**, how often have you had shortness of breath?

More than once a day	Once a day	3 to 6 times a week	Once or twice a week	Not at all
1	2	3	4	5

3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week	2 or 3 nights a week	Once a week	Once or twice	Not at all
1	2	3	4	5

4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times per day	1 or 2 times per day	2 or 3 times per week	Once a week or less	Not at all
1	2	3	4	5

5. How would you rate your **asthma** control during the **past 4 weeks**?

Not controlled at all	Poorly controlled	Somewhat controlled	Well controlled	Completely controlled
1	2	3	4	5

SCORE

TOTAL

If your score is 19 or less, your asthma may not be controlled as well as it could be. Talk to your doctor.

FOR PHYSICIANS:

The ACT is:

- A simple, 5-question tool that is self-administered by the patient
- Clinically validated by specialist assessment and spirometry[1]
- Recognized by the National Institutes of Health

Reference: 1. Nathan RA et al. *J Allergy Clin Immunol.* 2004;113:59-65.