



REFERRAL TO RBH DIFFICULT ASTHMA SERVICE

Name _____ Consultant _____

Referring Hospital _____ Asthma nurse _____

DOB

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Date of referral

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Referral Guidelines:

Please note these should serve as a guide and we are happy to accept referrals for patients who do not fulfill these criteria. However, for those that do, referral must be considered.

All children who meet the following criteria should be referred:

- Admitted to PICU because of an asthma attack
- Prescribed maintenance daily or alternate day prednisolone.
- Under consideration for other biological agent such as omalizumab

Consider referral for children who have poor control despite high intensity treatment:

High intensity treatment:

- Moderate dose ICS (BTS/SIGN guidelines): ≥ 800 mcg/day budesonide/beclomethasone or ≥ 500 mcg/day fluticasone plus long acting beta agonist

Poor control (please send copies of discharge summaries from the past year if available)

- Persistent chronic symptoms (most days for 3 months) or
- ACT or cACT < 20 or
- Severe exacerbations (≥ 2 / year requiring hospital admission or OCS) or
- Persistent airflow limitation ($FEV_1 < 80\%$ post bronchodilator) or
- Prescription of \geq salbutamol inhalers in the past year

Other considerations

- Diagnostic uncertainty
- Complex psychosocial issues (including safe guarding)
- Dysfunctional breathing / exercise induced breathlessness
- Enrolment in a clinical study

Prior to referral the following should be assessed (if possible):

Please provide further details overleaf or include in referral letter:

- Basis of asthma diagnosis
 - Documented wheeze by healthcare professional
 - Documented bronchodilator reversibility ($\geq 12\%$).....
 - Airway hyper-responsiveness (confirmed by direct or indirect challenge).....
 - Spontaneous variation in FEV_1 ($\geq 12\%$) or peak flow ($\geq 20\%$) in the past year.....
 - Diagnosis not confirmed.....
- Inhaler technique checked.....
- Allergy testing and identification of triggers
- Allergy avoidance advice (if applicable).....
- Prescription uptake checked.....



Further details if available (please complete the following or include in referral letter)

Current medications

Name	Dose

Exacerbations

- Number of hospital admissions in past year
- Number requiring oxygen
- Number requiring iv treatment
- Number of courses of OCS in past year

Assessments

Allergy testing (SPTs, slgEs):

Triggers:

Advice given:

Prescription check

ICS % uptake in past 12 months

Number of SABA inhalers collected in past 12 months:

Other relevant details