Severe and Difficult to Control Asthma Referral Tool

Section A
Should I refer this patient?

Refer patient, age 12 or older, with suspected severe asthma, if any are checked

Patient requires high dose ICS-LABA (or ICS + second controller) to control asthma †

OR

Patient needs systemic steroids for more than 50% of the previous year for their asthma

OR

Patient remains poorly controlled* despite adherence to moderate to high dose ICS-LABA treatment

† High dose ICS: >500µg beclomethasone dipropionate HFA; >800µg budesonide; >400µg ciclesonide; >500µg fluticasone propionate; 200µg fluticasone furoate; >400µg mometasone furoate

Refer patient with difficult to control asthma, if any values greater than recommended

Patient has experienced 2 or more exacerbations requiring OCS bursts in the past year

How many?

OR

Patient has presented to emergency department, walk-in clinic, or other urgent care because of their asthma in the past year

Number of times?

OR

Patient was admitted to hospital at least once in the past year because of their asthma

Number of Times?

OR

Patient is using 3 or more canisters of SABA annually, or 3 or more doses of reliever each week, despite adherence to ICS-LABA

Number of Canisters?

Please complete this section to the best of your ability. This information will provide more complete information, but is not necessary for the referral.

*Canadian Thoracic Society Asthma Control Criteria:
A patient must meet **ALL** the following criteria to be considered controlled

- Daytime symptoms less than 4 days per week;
- Night-time symptoms less than 1 night per week;
- Normal physical activity;
- Mild and infrequent exacerbations;
- No absence from work or school due to asthma;
- Fewer than 4 doses per week of reliever needed;
- FEV1 or PEF is 90% or greater of personal best;
- PEF diurnal variation is less than 10–15%

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Section B
Asthma Referral

Date

Urgency: ◯ Routine ◯ Urgent
If urgent, please provide further information:

Patient Name:

Referring Physician:

Health Card Number:

Physician Phone and Fax:

Phone number(s):

Date Of Referral:

Address:

Physician Address:

Current Asthma Treatment:

Previous Asthma Treatments (past two years, if known):

Which of the following have you assessed or treated in this patient, please choose if any applies:

- ☐ Chronic Rhinosinusitis
- ☐ Environmental Allergy
- ☐ Obesity
- ☐ Obstructive Sleep Apnea
- ☐ COPD
- ☐ Cardiovascular Disease
- ☐ Food Allergy/Eczema
- ☐ Depression / Anxiety
- ☐ GERD
- ☐ Current smoker

Attach the following test results, if available:

- Blood Eosinophil Count
- IgE levels
- Skin Prick testing / Allergen testing
- Pulmonary Function testing
- CXR / CT chest
- Spirometry
- Methacholine Challenge Test
- Other