

Asthma & Respiratory Management BOP Inc



Self – Referral Form

Full Name:

DOB:

Address:

Email:

Phone:

GP/Medical Centre:

Date:

Do you have? (Please circle)

- *Asthma*
- *COPD*
- *Another condition affecting your lungs, if so please explain*

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Why do you want an appointment with us? (Please circle)

- *Education about your condition/use of inhalers*
- *Worsening of COPD*
- *Worsening asthma symptoms*
- *Other:*

Are you prescribed inhalers? (Please circle)

YES NO

Do you use your inhalers every day? (Please circle)

YES NO

Do you understand why and how to use your inhalers? (Please circle)

YES NO

Have you been admitted to hospital with your asthma/COPD over the last 12months and if so how many times? (Please circle)

YES NO

How many courses of steroids have you had over the last 12months? (Please circle)

YES NO

*****Please note we cannot accept self-referrals for the hire of nebulisers or if you do not have a pre-existing diagnosis of a respiratory condition***