**Community Pharmacy Inhaler Check-up Service**
**Consultation Form**

CPWY Community Pharmacy West Yorkshire
Working to represent, support and promote community pharmacy

*Pharmacist/Pharmacy Technician* ..... *Consultation date* .....

**Patient consent to share information with GP** | **To proceed with the service you must confirm that we can share relevant information with your GP** | *Patient signature:*

**About the patient**

*Name* ..... *Date of birth* .....

*Gender* Male ☐ Female ☐ Prefer not to say ☐ *Ethnicity code* .....

*Address* ..... *Postcode* .....

*GP practice* .....

*Current diagnosis(es)* COPD ☐ Asthma ☐ Unknown ☐

*Smoking status* Smoker ☐ Prev. smoker <10 yrs ☐ Prev. smoker >10 yrs ☐ Never smoked ☐

**Current Care**

| | | |
|---|---|---|
| *Has GP or Nurse reviewed within 12 months?* | Yes ☐ | No ☐ |
| *Has asthma / COPD management plan in place?* | Yes ☐ | No ☐ |
| *Had flu jab this season? (add reminder)* | Yes ☐ | No ☐ |
| *Had COVID jab(s)* | Yes ☐ | No ☐ |
| *Been shown how to use device before?* | Yes ☐ | No ☐ |

*What device(s) are the patient prescribed?*

| | | | |
|---|---|---|---|
| Accuhaler ☐ | Forspiro ☐ | Breezhaler ☐ | Spiromax ☐ |
| Easi-Breathe ☐ | Easyhaler ☐ | Ellipta ☐ | Genuair ☐ |
| HandiHaler ☐ | MDI ☐ | NEXThaler ☐ | Respimat ☐ |
| Spacer ☐ | Turbohaler ☐ | Zonda ☐ | Other (specify) ☐ |

**Assessment**

*CAT / ACT score:* ☐

**Device Use Assessment**

| | | *Enter device name in row below (see example)* | | | |
|---|---|---|---|---|---|
| *(enter Y or N or N/A in box as appropriate)* | | E.g. MDI + spacer | | | |
| *Is **initial** observed technique good?* | | Yes | | | |
| *Can the patient inhale quick and deep for DPI or slow and steady for aerosol devices?* | | Yes | | | |
| *What problems were identified?* | *Use of device* | NA | | | |
| | *Management of condition* | NA | | | |
| | *Other (use notes below)* | NA | | | |
| *What actions were taken?* | *Advice on device* | Yes | | | |
| | *Support materials provided* | Yes | | | |
| | *Other advice /education* | Yes | | | |
| | *Other (use notes below)* | NA | | | |
| *Is final observed technique good?* | | Yes | | | |

*Is action by GP required?* Yes ☐ No ☐ *Which inhaler(s)?* .....

*Action for GP:* Consider change of device ☐ Consider Use of Spacer ☐ Consider further assessment ☐

*Reason for referral:*

.....

*Date of pharmacy follow-up (6-8 weeks):* .....

*Additional notes:*

## Community Pharmacy Inhaler Check-up Service – Follow-up Consultation Form

*Pharmacist / Pharmacy Technician:* ..... *Consultation date* .....

**About the patient** *Name* .....

*Has diagnosis changed?* No ☐ Yes – COPD identified ☐ Yes – Asthma ☐

*Has smoking status changed?* No ☐ Yes – started smoking ☐ Yes – stopped smoking ☐

**Current Care**

*What has happened to the patient's health or care since previous consultation?* *No change* ☐

*Other:*

*Has GP or Nurse reviewed within 12 months?* Yes ☐ No ☐

*Has asthma / COPD management plan in place?* Yes ☐ No ☐

*Had flu jab this season?* Yes ☐ No ☐

*What device(s) are the patient prescribed?*

| | | | |
|---|---|---|---|
| Accuhaler ☐ | Forspiro ☐ | Breezhaler ☐ | Spiromax ☐ |
| Easi-breathe ☐ | Easyhaler ☐ | Ellipta ☐ | Genuair ☐ |
| Handihaler ☐ | MDI ☐ | NEXThaler ☐ | Respimat ☐ |
| Spacer ☐ | Turbohaler ☐ | Zonda ☐ | Other (specify) ☐ |

**Assessment** *CAT / ACT score:* ☐

**Device Use Assessment**

| | | | *Enter Device name in row below* | | | |
|---|---|---|---|---|---|---|
| | | *(enter Y or N or N/A in box as appropriate)* | | | | |
| | | *Is **initial** observed technique today good?* | | | | |
| ***If initial technique not good*** | *Does In-check indicate device is appropriate?* | | | | | |
| | *What problems were identified?* | *Use of device* | | | | |
| | | *Management of condition* | | | | |
| | | *Other (use notes below)* | | | | |
| | *What actions were taken?* | *Advice on device* | | | | |
| | | *Support materials provided* | | | | |
| | | *Other advice /education* | | | | |
| | | *Other (use notes below)* | | | | |
| | *Is final observed technique good?* | | | | | |

*Is action by GP required?* Yes ☐ No ☐ *Which inhaler(s)?* .....

*Action for GP:* Consider change of device ☐ Consider use of Spacer ☐ Consider further assessment ☐

*Reason for referral:*

.....

*Additional notes:*

**National Ethnicity Codes**

National code Z should be used where the person is given the opportunity to state their ethnic origin but choose not to.

Ethnicity codes are used anonymously to ensure that individual ethnic groups are not disadvantaged or excluded from services.

White

| | |
|---|---|
| A | British |
| B | Irish |
| C | Any other White background |

Mixed

| | |
|---|---|
| D | White and Black Caribbean |
| E | White & Black African |
| F | White & Asian |
| G | Any Other mixed background |

Asian or Asian British

| | |
|---|---|
| H | Indian |
| J | Pakistani |
| K | Bangladeshi |
| L | Any other Asian Background |

Black or Black British

| | |
|---|---|
| M | Caribbean |
| N | African |
| P | Any other black background |

Other Ethnic Groups

| | |
|---|---|
| R | Chinese |
| S | Any other ethnic group |
| | |
| Z | Not stated |