Reset Form | Print Form

BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority

ASTHMA DISCHARGE INSTRUCTION
ASTHMA PROGRAM REFERRAL
Please fax referral to 604-875-3653

Patient Name: **DOB:** **MRN:**

REFERRAL: The asthma program will call you with an appointment.

Reason for Referral Program:

Other Specialists Involved in Care:

Specialist Name:

PREVENTER MEDICATION - use every day, reduces swelling and mucous in the airways.

Medication Type: Inhaler

puff(s) time(s) per day until re-assessed by your doctor. **Next Dose:**

Medication Type: Oral

time(s) per day until re-assessed by your doctor. **Next Dose:**

***** Always drink water or rinse mouth with water after each use. *****

RELIEVER / RESCUE INHALER – Relaxes tight muscles around the airways, starts working within 5 minutes and should last 4 hours.

puff(s) every hours for days then puff(s) every hours as needed.

ORAL STEROID – Reduces airway swelling.

mg (milligrams) by mouth once a day for days. **Next Due:**

OTHER MEDICATIONS

Medication Name	Dose	Directions	Duration

Follow up with primary care physician in 2 – 5 days.
If symptoms worsen, see back of purple pamphlet - "Control Asthma Now".

MD Signature **Date/Time** **Parent/Guardian/Patient's Signature**

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NAME: **WEIGHT:** **Date:**

℞

MD Name / College ID #: (PRINT):	MD Signature:
REPEAT	☐ NO REPEAT

updated March 2013