## Respiratory warrant of fitness checklist and consent form

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| --- | --- | --- | --- |
| **Patient name:** |  | | |
| **Address:** |  | | |
| **Phone number:** |  | **Mobile:** |  |
| **DOB** |  | **Ethnicity:** |  |
| **GP name:** |  | **NHI number:** |  |
| **GP phone number:** |  | **GP address:** |  |

## Initial consultation

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| --- | --- |
| **Do you have asthma?**  *If ‘No’ then can still do education but cannot be a part of the project* | Y  N |
| **Are you willing to take part in the project?**  *Explain what the Respiratory WOF entails and give information leaflet to read* | Y  N |
| **Are you happy for one of our staff to follow you up monthly with a phone call?**  *If ‘No’ then can still do education but cannot be a part of the project* | Y  N |
| **What is your current Asthma Control Test score?**  *Explain what the ACT is and If not already completed then complete*  *(‘ACT gives us an idea of where your asthma control is at right now’)* | Score = |
| **What is your goal Asthma Control Test score?**  *(your ACT goal is where you would ideally like to see your asthma control at’)* | Score = |
| **Do you have a spacer to use with your inhaler(s)?**  *If ‘No’ then provide and demonstrate use when discussing inhalers* | Y  N |
| **Do you use a preventer inhaler?**  *If ‘yes’ or they should be using a preventer then do education (see next page)* | Y  N |
| **Do you use a reliever inhaler?**  *If ‘yes’ or they should be using a reliever then do education (see next page)* | Y  N |
| **Have you had the flu vaccination this year?**  *If ‘No’ then offer, and check if qualifies for funded option* | Y  N |
| **Do you or anyone you live with currently smoke?**  *If ‘yes’ then offer smoking cessation advice* | Y  N |

| Information checklist for patient | | | Completed ✓ |
| --- | --- | --- | --- |
| Preventer  * Explain what preventer inhaler is * Adherence/usage * Check technique +/- spacer * Rinse mouth * Provide written information if needed | | |  |
| Reliever  * Explain what reliever inhaler is * Check technique +/- spacer * Check frequency of use (if using often then discuss review by GP for asthma management) * Provide written information if needed | | |  |
| Tips (where appropriate)  * Sports – remember to bring inhaler * Allergy control * Ensure have extra inhaler so does not run out unexpectedly * Delivery services * Repeat reminder system | | |  |
| Further education (where appropriate)  * Smoking cessation (for patient and/or whānau) * Discuss referral to Breathe Hawkes bay or Respiratory nurse champions | | |  |
| Others notes or interventions completed: | | |  |
| Questions answered by  (patient or guardian name): |  | Date: |  |

|  |  |
| --- | --- |
| Date and time completed | |
| Completed by  – Name of pharmacist: |  |
| Signature: |  |