## 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
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| 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
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| 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: |  |

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