Office of the School Nurse

REFERRAL FOR RESPIRATORY EVALUATION

Name:_____Date:_____

History:

[ ] No known history of respiratory problems
[ ] History of asthma/respiratory problems (list when)
[ ] Has asthma
[ ] Currently having asthma exacerbation
[ ] Allergies (list):_____
_____

Current Status:

S:_____

O:

Peak Flow Reading 100-80%_____ 80-65%_____ 65-50%_____ 50%_____

Respiratory Rate: _____ Pulse Rate: _____

[ ] Coughing
[ ] Wheezing
[ ] Retractions
[ ] Rhinitis
[ ] Shiners
[ ] Others_____

A:_____

P:
[ ] Start Peak Flow monitoring program at school & home
[ ] Asthma information to parent
[ ] Refer for Asthma education
[ ] Refer to MTF for further evaluation

For the Physician:

S:_____

O:_____

A:_____

P:
[ ] No treatment at this time, but recommend_____
[ ] Prednisone burst (#days)_____
[ ] Nebulizer Treatment (how many)_____
[ ] New medications prescribed (attach permission & plan)
[ ] F/U on (date)_____
[ ] Refer to asthma education class
[ ] Asthma Management Plan (attach)
[ ] Referral to _____

_____ _____
Physician Signature/Stamp Date