Date: [Insert Date]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Patient ID: [Insert Patient ID]

Dear [Insert Patient Name],

This letter is to confirm your routine asthma medication management plan as discussed during your recent clinical review. Regular use of your prescribed medication is essential for maintaining good lung function and preventing asthma attacks.

Prescribed Controller Medication:
[Insert Medication Name and Dosage]
Frequency: [e.g., Two puffs every morning and evening]

Prescribed Reliever Medication (For Rescue Use Only):
[Insert Medication Name and Dosage]
Frequency: [e.g., Two puffs as needed for shortness of breath or wheezing]

Important Instructions:

- Continue taking your controller medication daily, even if you feel well.
- Always carry your reliever inhaler with you for emergencies.
- Ensure you are using the correct inhaler technique. If you are unsure, please contact the clinic for a demonstration.
- If you find yourself using your reliever inhaler more than three times a week, please schedule an appointment for a review.

Your next routine asthma review is due on: **[Insert Date]**.

If you experience a severe worsening of symptoms or your reliever medication does not provide relief, please seek immediate medical attention.

Sincerely,

[Doctor/Provider Name]
[Clinic/Facility Name]
[Contact Phone Number]