Putting on AIRS

REFERRAL FORM

Patient Name:____DOB:___________________

Parent/Guardian Name:____

Address (Street/City/Zip):____

Phone Number:________________________________Alternate #:_________________________________

Preferred Language: ____

Email Address ____

Diagnosis of Asthma in past 12 months   Diagnosis of Asthma over 1 year ago ☐

<u>Asthma Action Plan REQUIRED prior to first home visit. Please send with referral. **</u>**

<u>Documentation pertaining to legal guardian REQUIRED if not parent. Please send with referral. **</u>**

<u>Eligibility requirements: one or more of the following criteria.   Check all that apply</u>

The following questions pertain only to asthma

Poorly Controlled as defined by Asthma Control Test (<19)	
$\geq$1 ED visit or hospitalization or unscheduled medical visit in the last 6 months	
$\geq$1 unscheduled medical visit in the last 6 months	
Non adherent to inhaled Corticosteroids	
Self-Administered 3 rescue inhalers in 6 months	
Activity limits due to asthma	
School Absences: missed $\geq$ 2 school days in the last year	
School nurse's office visit > 2/week	
Work Absenteeism: missed $\geq$2 workdays in the last year	

Areas of Concern:

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Physician Name:____

Name of Practice:____

Address (Street/City/Zip):____

Phone Number:____

PLEASE FAX THIS FORM TO:
Putting on AIRS
(203) 381-2048

For information or questions contact the Stratford Health Department (o) (203) 385-4090 or (m)203-581-0428 or asthma@townofstratford.com