Asthma Home Visit Referral

Fax to 617-534-2372

Family Agrees to referral: ☐Yes ☐No ☐Would benefit from program (Provider did not ask)

Referral Information

Date of referral:		Referrer name:
Phone:	Fax:	Email:
Referrer is: ☐PCP ☐Asthma/Allergy Specialist ☐Nurse ☐Other:		

Patient Demographic Information *Required

*Patient NAME:	
D.O.B:	*Insurer & Insurance #:
	*Medical Record #:
Language:	
Parent/Caregiver name:	
Address:	
Tel:	Cell:

Primary Care Information (If known)

◆PCP Name:	
PC Site:	
Phone:	Fax:
Asthma Care Coordinator or comparable:	
Name:	Phone:

*Reasons for Referral (check all that apply, if known)

☐Poorly-controlled persistent asthma
☐Hospital admission for asthma exacerbation in last **12 months**
☐Repeated ER or urgent care visits for asthma in last **6 months**
☐Overuse of rescue medication in last **6 months**
☐More than one course of oral steroids in last **6 months**

Concerns about home environmental triggers (check all that apply)

○Pollen ○Tobacco Exposure ○Molds ○Mice
○Roaches ○Dust Mites ○Animal Dander
○Other:

Additional Reasons for Referral (check all that apply)

☐Concerns about medication adherence
☐Needs help with medication administrative technique

Other Pertinent Information

◆Allergy testing conducted*:
☐Yes ☐No

◆Positive allergy testing results to:
○Pollen ○Dust-mite ○Mice
○Roaches ○Animal Dander
○Other:

*We strongly encourage allergy testing, as recommended in the National Asthma Management Guidelines. Research shows that allergy test results help providers tailor interventions for improved health outcomes.

Asthma Action Plan (please attach/complete below) *Required

◆GREEN ZONE Peak Flow Value _____
☐*Controller medications: _____
☐*Allergy medications: _____
Other/How Often: _____

◆YELLOW ZONE Peak Flow Value _____
☐*Rescue medications: _____
Others/How Often: _____

◆RED ZONE Peak Flow Value _____

Equipment Used (check all that apply)

○Nebulizer ○Spacer with mask
○Spacer ○Peak Flow

Others Requesting A Report Back

(If not PCP or referrer, include contact information):

○Specialist: _____
○Insurer: _____
○Other: _____