

Patient
Label/Stamp

Asthma Clinic:

___ Allergy-Asthma Fax: 504.903.1605
___ Pulmonary-Asthma Fax: 504.903.2149

Referral from: ___ BMC ___ EKL ___ LJC ___ LAK
___ LIH ___ UMC ___ WOM ___ Other: _____

Attending Provider: _____ ID Number: _____

If Label/Stamp is Not Available Complete the Following:

Patient's Name: _____ Date of Referral: ___/___/___
Date of Birth: ___/___/___ Medical Record Number: _____

(493.90 Asthma) Indicate Reason for Referral: (Check all that apply)

- ___ 1. Severity Class: ___ Severe Persistent ___ Moderate Persistent
___ 2. Poor control in the past 12 months: ___ >2 ER visits OR ___ 1 or more Hospitalizations
___ 3. Prednisone bursts ≥ 2 within the past 12 months: ___ yes ___ no
___ 4. Other _____

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Please provide the following:

1. Most recent PEFR/FEV1 _____ DATE: ___/___/___ Asthma Control Test Score: _____
2. Date of last Pulmonary Function Test: ___/___/___ or Date Ordered: ___/___/___
3. Patient has Asthma Action Plan: ___ yes ___ no

Current Medications: Asthma _____ Leukotriene Receptor Antagonist
___ Short Acting Beta 2 Agonist _____ Theophylline Derivative
___ Long-acting Beta-2 Agonist _____ Ipratropium
___ Steroid (inhaled) _____ Cromolyn Sodium
___ Steroid (oral)

Other Current related medications: _____ ACE Inhibitors
___ H2 Blockers _____ Beta Blockers
___ Proton Pump Inhibitors _____ Nitrates
___ Steroid Nasal Spray _____ Vasodilators
___ Diuretics

Clinical History Relevant to this Referral: _____

Referring Provider's Signature: _____ ID Number: _____

Contact Number: _____ Referring Service/Clinic: _____

Fax Number: _____ Email: _____

OFFICE USE ONLY: Appointment Date: ___/___/___ Time: ___:___ am/pm.

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

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