

Patient Label/Stamp

Asthma Education Referral

Fax 504.903.0217

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

Attending Provider: _____ ID Number: _____

If Patient Label/Stamp is Not Available Complete the Following:

Patient's Name: _____ Date of Referral: ____/____/____

Date of Birth: ____/____/____ Medical Record Number: _____

Mailing Address: _____

1° Contact Number: ____-____-____ 2° Contact Number: ____-____-____

Email Address: _____

Please check all that apply:

- Inpatient
- Outpatient
- Emergency Department
- Change in Treatment Plan

Please indicate needed services: (V65.4)

- Disease Process: Asthma
- Inhaler/Medication Administration
- Peak Flow Monitoring
- Disease Management (Action Plan)

Current Medications: (Asthma)

- Short Acting Beta 2 Agonist
- Long-acting Beta-2 Agonist
- Steroid (inhaled)
- Steroid (oral)
- Leukotriene Receptor Antagonist
- Theophylline Derivative
- Ipratropium
- Cromolyn Sodium

Clinical History Relevant to this Referral: _____

Referring Provider's Signature: _____ ID Number: _____

Provider's Contact Number: ____-____-____

Email: _____

Referring Service/Clinic: _____

Fax Number: ____-____-____

Office Use Only: Appointment Date: ____/____/____ Time: __:__ am/pm. Location: _____

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: ____-____-____

Rev 2.19.09