# 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 #: |
| Language: | |
| Parent/Caregiver name: | |
| Address: | |
| Tel: | Cell: |

## Primary Care Information (If known)

| | |
|---|---|
| ◆PCP Name: | |
| PC Site: ○ Tufts ○ Other: | |
| Phone: | Fax: |
| Pedi Triage/Asthma Care Coordinator: | |
| 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: _____