ECU HEALTH
Maynard children's Hospital

Pediatric Asthma Program Referral Form

HOW TO MAKE A REFERRAL:
Phone #: (252) 847-6835
Fax #: (252) 847-6859
Email: PediatricAsthmaTeam@ecuhealth.org
Submit through EHR: Send an in-basket message to P Ip EMC Pool - Peds Asthma Team

Date: _____ Date of Birth: _____

Name: _____ Age: _____

Parent/Guardian Name: _____

Address: _____

Phone: _____ School/Daycare: _____

Doctor: _____ Insurance: _____

PLEASE ATTACH ASTHMA ACTION PLAN:

_____

☐ **PARENT INFORMED OF REFERRAL**

REFERRED BY: _____

REASON FOR REFERRAL:

☐ SOCIAL CONCERNS *(financial/insurance, indigent medicines, non-compliance with appts., etc.)* **Explain Below**

☐ EQUIPMENT NEEDS *(spacer, peak flow meter)*

☐ REINFORCEMENT OF EDUCATION *(1-2 visits)*

☐ CASE MANAGEMENT SERVICES *(problematic/complex patients)*

Other Comments: