Mission Children's Hospital
Regional Asthma Disease Management Program
11 Vanderbilt Park Drive, Asheville, NC 28803
828-213-8245; FAX 828-213-8251

REGIONAL ASTHMA DISEASE MANAGEMENT PROGRAM PATIENT REFERRAL

Name _____ Preferred Name _____ Date_____

DOB _____ Age _____ Sex _____ School Attending _____

Language _____ Is an interpreter needed? __ Yes __No

Mailing Address _____

Home Phone _____ Race/Ethnicity _____

Parent/Guardian Information:

Parent/Guardian Name _____

Address _____

Cell Phone _____ Work Phone _____

Other Contact _____ Relationship _____

Address & Phone Number _____

Referral and Insurance Information: Please send insurance card copy (front and back)

Referring Healthcare Provider _____ Phone _____

Primary Care Physician (if other than referring) _____

Office Address _____

Name of Insurance _____

Medicaid/Carolina Access Referral Number _____ NPI Number _____

TO BE COMPLETED BY REFERRING PROVIDER / PRIMARY CARE PHYSICIAN

Medical Reason for Consult: _____

Does the parent/guardian understand the reason for the consultation with this provider? __ Yes __ No

If no, list the reason _____

Current Asthma Action Plan: _____

Current Medications: _____

_____

Patient's Height _____ Weight _____ Date _____

To assist with the appointment, please send: Insurance card copy (front & back), growth records/charts, laboratory & radiology studies, relevant H&P including most recent office notes, and any other information pertinent or concerns.

Please rate the urgency of your referral: Routine__ Semi-Urgent __ Urgent__ (list reason) _____

Referring Physician Office contact name _____ Phone _____

Provider Signature _____ Date _____

Print Name of Provider _____

Please Fax this referral form to the Regional Asthma Disease Management Program at 213-8251.