Albany County Department of Health **Phone# (518) – 447-4615**

ASTHMA EDUCATOR REFERRAL FORM

Family Agrees to referral: Yes____ No____ Lives in Albany County: Yes____ No _____

Date of Referral: ________________ Source of Referral/Phone: ____________________________________

Name of Adult Contact: ________________________________ Phone #: ____________________________

Referral for: ____ DOB: ________________________________

Address: ____

Primary Language: ____

Criteria for Referral: (check all that apply)

_____ Poorly-controlled persistent asthma
_____ Hospital admission for asthma exacerbation in the last 12 months
_____ Single ER or repeat urgent care visit for asthma in last 12 months
_____ Overuse of rescue medication in last 6 months
_____ Prescription for oral steroids in last 12 months
_____ Concerns about home environment triggers in combination with poor control
_____ Concerns about medication adherence
_____ Needs help with the medication administration technique

Other Potential Triggers

_____ Parent/Guardian Smokes
_____ Patient Smokes
_____ Secondhand Smoke Exposure
_____ Roaches
_____ Mice
_____ Animal Dander
_____ Chemicals (Cleaning, Pesticides)
_____ Molds
_____ Dust Mites
_____ Other: ____

Other Pertinent Information:

Allergy testing conducted: Yes____ No_____
Positive allergy results:
Pollen _____ Animal Dander _____ Mice _____ Roaches_____ Dust Mites_____ Mold_____
Other: ____

HNP Form Attached: Yes _____ No ____

Names of all Adults/Children in the home that have Asthma and would like a Home Visit:

Name: ______________________________________ DOB: ________________________

Name: _______________________________________ DOB: ________________________

Please FAX to Lucretia: 518-447-5908