

# Putting on AIRS Region 1 Referral Form

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Please Fax referral to :( 203)346-3903. Attention: POA Coordinator-Nicholas Palermo

Or E-mail to: npalermo@waterburyct.org

Referral Source- Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address (Street, City, and Zip): \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Please check any that apply

- $\geq$  1 ED visit or hospitalization or unscheduled medical visit in the last 6 months due to asthma.
- Self-administered 3 rescue inhaler canisters in 6 months.
- Activity limitations due to asthma.
- School absences: missed > 2 school days in the last school year due to asthma.
- School nurse's office visits > 2/week due to asthma.
- Work absences: missed > 2 work days in the last year due to asthma

Did you discuss this *Putting on AIRS* referral with the patient? Yes / No

Would the patient like to be contacted by the *Putting on AIRS* coordinator? Yes / No

Primary care physician (Name/City): \_\_\_\_\_

Asthma Specialist (Name/City): \_\_\_\_\_

Medications/Dosage: \*\*\*Please attach Asthma Action plan or Medication list\*\*\*

Comments:

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