



Texas Children's Health Plan

The best decision a family can make.

# ASTHMA DISEASE MANAGEMENT REFERRAL FORM

Phone: (832) 828-1430

Fax: (832) 825-8745

Date \_\_\_\_\_

Your Name: \_\_\_\_\_

Office Number: \_\_\_\_\_

Member ID: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Member Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Sex: M or F (circle one)

Primary Language: \_\_\_\_\_

Asthma Diagnosis Code(s): \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Member/Parent Contact Info: Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

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

Referring Provider: Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**ASTHMA INFORMATION:** Has Written Asthma Action Plan: \_\_\_ Yes \_\_\_ No

ER visits for Asthma—# in last year \_\_\_\_\_ Hospital Admissions for Asthma—# in last year \_\_\_\_\_

Asthma medications Member is using: \_\_\_\_\_

## REQUESTS:

\_\_\_ Home visit for Asthma Education Class and provide/dispense asthma tools/DME as needed to assist member with managing their condition. Please sign below to order home visit

\_\_\_ Member needs education by phone or mail for:

- |  |  |
|--|--|
| <input type="checkbox"/> How to follow an asthma action plan | <input type="checkbox"/> Recognizing and avoiding triggers |
| <input type="checkbox"/> Correct use of medications          | <input type="checkbox"/> Correct use of delivery devices   |
| <input type="checkbox"/> Other education _____               |  |

\_\_\_\_\_  
Provider's Signature