St. Mary's Healthcare Amsterdam
Care You Can Trust

ASTHMA HOME VISIT REFERRAL

380 Guy Park Ave
Amsterdam, NY 2010

Date of Referral:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:

Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Chose reason for asthma home visit referral: (Select all that apply)
❑ Uncontrolled Asthma ❑ 2 or more ER visits in last 6 months
❑ hospital admission in past 12 months ❑ Overuse of rescue medication ❑ Failed medication adherence ❑ social concerns ❑ Other

Comments:

HEALTH HISTORY

Medical History:

Current Medications:

Social Barriers for controlling asthma: ❑ Homeless ❑ Smoker ❑ Insurance ❑ Transportation ❑ Support
❑ Mold in home ❑ Pest problem ❑ Pets in home

Comments:

Person Referring: (Include Phone Number)

REFERRAL

Please Fax Referral to:
518-841-7121
Phone: 518-770-6803
Attention Angela Fraumane BSN, RN AE-C

For St Mary's Healthcare Staff Only:
Date Referral Received:
Completed By:
Date of Appointment:
Sent to CHC (Community Health Center) ○Yes ○ No