REFERRAL TO BALTIMORE CITY ASTHMA PROGRAMS

Fax this form to: (410) 244-1366 **Referral Source: _____**

Attention: Referral Coordinator **Date of Referral**: _____/_____/_____

Baltimore City Health Department: Community Asthma Program
7 E. Redwood Street, 2nd Floor
Baltimore MD 21202
Phone: (410)396-3848

Please Mark Which Program(s) you wish to refer to:

☐ **Baltimore City Home Visiting Programs: Eligibility:**

- **Have a moderate to severe asthma diagnosis**
- **Be a Baltimore City resident between 2-18 years old**

☐ **The Baltimore City Community Asthma Education Groups: Eligibility:**

- **Have or care for a child with an asthma diagnosis**

Child's Name: (first) _____ (last) _____

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ M ☐ F

Caregiver's Name: (first) _____ (last) _____

Address: _____ Apt. #:_____

_____

Home: (_____) _____ work: (_____) _____Cell: (_____) _____

Leave a message: ☐ Y ☐ N Interpreter Needed? (Specify language) _____

Clinic Name: _____ Clinic Phone: (_____) _____

School Name: _____ School Phone: (_____) _____

Person Providing Referral _____ (MD, ARNP, RN, PHN, parent/guardian, school)

Phone Number of person providing the referral :__(_____)_____

Fax Number of person providing the referral: ___(_____)_____

Is the family aware of referral? ☐ Yes ☐ No

Note Additional Information: