



COMMUNITY  
MEDICAL CENTERS

*Asthma Education Program*  
**\*\* REFERRAL FORM \*\***

Please print information below and fax to: (559) 459-3513

Medical Record Number: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ (Circle One) Male or Female

*If the patient is a minor please give us (mom/dad or guardian's name)* \_\_\_\_\_

Patient's Address: \_\_\_\_\_ Apt: \_\_\_\_\_

Phone:(H) \_\_\_\_\_ (W) \_\_\_\_\_ (Other) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PCP Name: \_\_\_\_\_ Facility: \_\_\_\_\_

Please check the appropriate box and list any pertinent information below:

Asthma     RAD     COPD     Bronchitis     Other \_\_\_\_\_

Comments/Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*\*\* Please let patients know to bring all asthma medications and devices with them to their appointment. \*\*\* Please FAX a copy of the patient's insurance card and HMO referral forms with the referral. Thank you.

Name of person filling out Referral: \_\_\_\_\_ Date: \_\_\_\_\_