COMMUNITY MEDICAL CENTERS

Physician Referral and Order Form

Asthma Education & Management Program

Phone (559) 459- 3554 • FAX (559) 459-2083

(To assure prompt scheduling, all sections of referral form must be completed including ICD-10 code & physician signature)

Contact Person: _____ Office Tel: _____ FAX: _____ Date: _____

Referring Physician: _____ Primary Physician (if different): _____

Patient Name: _____ DOB: _____ Language: _____

Parent/Guardian if patient is a minor: _____Med Record#_____

Address: _____ Apt# _____ City: _____State: _____ Zip: _____

Daytime Phone #: (_____)_____ Evening Phone #: (_____)_____

Insurance: ***Please FAX a copy of the patient's insurance card with the referral form.***

Name of Insurance: Primary: _____ Secondary: _____

pre - authorized visits: _____ Authorized for group sessions: ☐ Yes ☐ No

Referral #/Authorization # _____ Exp. Date: ___/___/_____

Asthma Education & Management

Please check at least one of the following:

☐ **Asthma**
ICD-10 Code:_____

☐ **RAD**
ICD-10 Code:_____

☐ **COPD**
ICD-10 Code:_____

☐ **Other**_____

_____

_____

Asthma History

Please check all that apply :

☐ Asthma Emergency Visit _____

☐ Asthma Hospitalization _____

☐ Current Asthma Medications _____

_____

☐ Other _____

_____

Physician signature (required) and Provider NPI

_____

Please fax signed referral to:

559-459-2083

Asthma Education Appointment:

_____

Date: Time:

Please bring all asthma medications and tools (spacer and peak flowmeter) with you to your appointment.