Our Goal, Asthma Control
Through Asthma Home Care Visits and Care Coordination

Requirements for Referral:
Patient with diagnosis of Asthma
Patient with Medicaid coverage

We provide home visits in which we:

- Provide patient centered asthma self-management education, trigger identification and trigger management counseling, including routine review of an asthma action plan.

- Complete environmental assessment, education, and trigger mitigation, including referrals for Integrated Pest Management (IPM).

- Provide referrals for smoking cessation programs, legal services, public assistance support, and behavioral health as necessary.

- Provide navigation services including support for patients in accessing and utilizing medical resources.

Please fax the Referral Form to (718)-963-6425. Thank you!

Our care coordinator will contact your office with a report regarding the home visit findings and recommendations to improve asthma control for our clients.

If you have any questions please call Danielle Barnes, Asthma Program Manager, at (718) 963-6490.

Thank you!
ASTHMA HOME CARE REFERRAL FORM

Referral Source:____________________________________________ Date of Referral: _______________

Office Phone Number:__________________________ Office Fax Number: ________________________

Office Mailing Address:__________________________________________________________________

Patient’s Name:__________________________________________________________________________

Patient’s Age:__________________ Male or Female Date of Birth:_____ / _____ / ______

Insurance: _____________________________________________________________________________

NY Medicaid ID# (Starts with 2 letters, then 5 numbers, then a letter) :__________________________

Patient’s Address: _________________________________

_________________________ NY _______________ (zip)

Patient’s Phone Number: (h)____________________ (w) ______________________ (other)______________

Asthma Severity (if known):______________________________________

Asthma Control (if known):______________________________________

If patient is a minor:
Parent/Guardian Name:______________________________________

Preferred language:

ENGLISH
SPANISH
OTHER: __________

Name of PCP:______________________________________

Group Name:______________________________________

Address:______________________________________

_________________________ NY _______________

Phone: (_____) _______ - __________

Please fax completed form to (718)-963-6425. If you any questions please call Danielle Barnes at: (718) 963-6490. Thank you!