



## COMMUNITY ASTHMA PROGRAM (CAP)

### ASTHMA and HEALTHY HOME VISIT REFERRAL FORM

Your healthcare team would like to refer you to the Baltimore City Health Department's (BCHD's) **Community Asthma Program** so that you can receive follow-up with an offer of asthma home visits to help you manage your child's asthma.

With your permission, we will fax this referral form to BCHD's Asthma Intake Coordinator so that you can be contacted by **BCHD's Community Asthma Program** within the next few days by phone or email.

**BCHD offers free home visits to Baltimore City families to help reduce your child's asthma symptoms by providing asthma information and supplies, assessing environmental triggers in the home, and providing information on resources and services with the goal of making your home healthier. These services do not cost you any money.**

Referral Date: \_\_\_\_\_

Clinic/Practice/Hospital/Organization: \_\_\_\_\_

Person Providing Referral: \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

Child's Name: (first) \_\_\_\_\_ (last) \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Parent/ Guardian Name: (first) \_\_\_\_\_ (last) \_\_\_\_\_

Home Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Best Contact Number: (\_\_\_\_\_) \_\_\_\_\_  cell phone  home phone

I agree to share this information with Baltimore City Health Department's Community Asthma Program

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE FAX THIS SIGNED FORM TO BCHD at 410-244-1366**

**QUESTIONS? CALL BCHD at 410-396-3848**