



PO Box 3948 • Albuquerque, NM 87190-3948 • www.asthmaallies.org

# ASTHMA EDUCATION REFERRAL FORM

Fax Request to 505-205-1462

Phone: 505-259-6277 • Email: admin@asthmaallies.org

## PATIENT INFORMATION:

Patient Name		DOB	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Parent/Guardian/Caregiver Name (if applicable)			Email	
Address		City	State	Zip
Insurance		Age	Home Phone	Work or Cell Phone
Primary Care Provider		Provider Phone		Provider Fax
		Provider Address		
Asthma Specialist (if applicable)		Provider Phone		Provider Fax
		Provider Address		

## PROGRAM/SERVICES REQUESTED: (check all that apply)

- Comprehensive Asthma Management Program (C.A.M.P.)
- Home Visit Asthma Management Program (H-VAMP)
- Group Education Series
- Individualized Program (Topic Specific)

## SPECIAL NEEDS: (check all that apply)

- Language Spoken \_\_\_\_\_
- Physical/Mental challenges \_\_\_\_\_
- Vision or Hearing limitations \_\_\_\_\_
- Other \_\_\_\_\_

## MEDICATIONS: (please list)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ASTHMA TOOLS USED: (check all that apply)

- Nebulizer
- Spacer/Holding Chamber
- Peak Flow Meter
- Frequency:  Twice a day  Daily  Only when sick

## UNSCHEDULED ASTHMA VISITS: (over past 12 months)

- Emergency Room Visits:      How Many? \_\_\_\_\_
- Urgent Care Visits:            How Many? \_\_\_\_\_
- Office Visits:                    How Many? \_\_\_\_\_

## SPIROMETRY: (please attach most recent spirometry results)

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

## PROVIDER CERTIFICATION:

As the healthcare provider treating this patient's asthma, I certify that asthma self-management training is needed under a comprehensive plan for this patient's asthma care to ensure therapy compliance and/or to provide the necessary skills and knowledge to enable the patient to manage his/her condition.

Provider Signature	Date
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## For office/scheduling use:

Initial Contact (Date & Initials)	Complete Intake Completed (Date)	Current Spirometry?	AE-C Appointment (Date)	AE-C Assigned
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## ASTHMA SELF-MANAGEMENT EDUCATION

### Plan of Care

All asthma education will be conducted by a certified asthma educator (AE-C®)

Group and individual visit formats are available for patients.

Once a comprehensive program is completed, annual follow-up education is recommended.

All patients enrolled in a comprehensive program will receive a set of asthma management tools.

Regular communication with referring provider will occur after each visit that patient has with the AE-C®

### Comprehensive Asthma Management Program (C.A.M.P.)

This program coordinates care and education for patients with asthma. The program involves the patient's family, their healthcare providers, and work or school. This is a 6-month program consisting of 6-8 hours of face-to-face education with telephonic follow-up. The program includes:

- Education visits
- Family referrals and follow up
- School in-service
- Asthma management tools
- Physician care conference

### Group Education Series

These classes cover a wide variety of topics and are appropriate for basic overview and follow-up education. Education is conducted through a 3-visit series. Each class lasts for 90-minutes.

### Home Visit Asthma Management Program (H-VAMP)

This in-home visit program focuses on asthma and creating a healthy home environment conducive to successful asthma self-management. This is a 6-month program consisting of 6-8 hours of face-to-face education with telephonic follow-up.

H-VAMP includes:

- Initial evaluation
- Education visits
- Family referrals
- Asthma management tools
- Home environment remediation kit
- Physician Care Conference

### Individualized Program (Topic Specific)

The Individualized Program coordinates care and education for the patient. The referring provider selects areas of need or improvement for topics. Each patient will have 1-2, 1-hour visits, depending on the topic. There are no follow-up visits.

### Medical Information Release

With the goal of improving my (my child's) health, I give Asthma Allies permission to discuss any medications, treatments, appointments, and management plans, related to or affecting my (my child's) asthma management with my (my child's) healthcare provider and/or office staff.

Patient Signature	Date	
Parent/Guradian/Caregiver Signature	Relationship	Date

### Asthma Education Staff Only

This care plan was reviewed with the patient. The patient agrees that this plan is acceptable and that he/she will participate in the specified asthma self-management program.

Patient Signature	Date
Staff Signature	Date