# CHOC Breathmobile™ SCHOOL Referral Form

(714) 509-7571 Appointment Line (855)212-6740 Fax Line

**Please fax completed form to Breathmobile office @ (855)212-6740**

## Student/Patient Information

Child's Name: _____ Date of Birth ____/____/____

Home Address: _____ Apt: ____ City _____ Zip Code _____

Mother/Guardian Name: _____ Father/ Guardian Name: _____

Home Phone Number: _____ Work/Cell Number: _____

**Does Child have Health insurance?** □ **Y** □ **N** Insurance : □ MediCal □ Private/Kaiser Other_____

Primary care provider_____

## Reason for Referral:

**Reason for referral**:_____

_____

_____

□ Frequent use of albuterol at school

□ Missed school days

□ Unable to participate in school activities due to asthma

□ no asthma diagnosis but has asthma symptoms.

## Referring Agency/School

Referral Date: _____

Referring School : _____

Referred By Name):

_____

Phone Number: _____

Best Time to Call: _____

Fax Number (For Follow Up):

_____

## Office Use Only:

□**Patient Appointment Scheduled:**

Date: _____ Time: _____ Location: _____

□ **Parent Declined Service:** Date: _____

□ **Unable to Contact Dates Attempted:**

_____ _____ _____

Date Date Date

□Faxed back to Referring Location _____

□**Refer back to PCP for further evaluation**

□**Please provide further information**

Completed by: _____ Title: _____