REFERRAL: ASTHMA EDUCATION

I am referring my patient to Asthma education for self-management skills.

Date: ________________________________ DOB: ________________

Patient Name: ____________________________________________

Home Phone: ____________________ Work Phone: ____________________

Physician Name: _________________________________________________________________________________________________

Location: __________________________________________________________ Phone #: __________________________

All of the following will be included:

- Basic facts about asthma
- Identification and control of asthma triggers
- Medication usage
- Correct use of inhalers and spacers
- Peak Flow Meter monitoring
- Asthma Action Plan

Education (by appointment - 414.649.6064)

Location: _________________________________________________________________________________________________

Special needs include:

- Vision
- Hearing
- Language limitations
- Physical limitations
- Other ____________________________________________________

Please check all that apply:

- Patient has an Asthma Action Plan
- Patient needs a peak flow tracking form
- Patient needs a peak flow meter
- Patient needs a spacer

Fax order to: 414-649-5621
Asthma Education office: 414-649-6064
Online registration: www.aurorahealthcare.org/events/index.asp
(enter “Asthma” in keyword search)