CHOC Breathmobile™ Provider Referral Form

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

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

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 Type: ▫ MediCal Other_____________

Primary care provider______________________ Were notes faxed to Breathmobile ▫Y ▫ N

Was Authorization processed by Choc Health Alliance: Auth# ______________________________

Reason for Referral:

Reason for referral:____

Is Child a Breathmobile Patient ▫Y ▫ N

Is Child < 37 weeks? ▫Y ▫N

Is Child Diagnosed with Cystic Fibrosis? ▫Y ▫N

Any history of Complex Heart Disease? ▫Y ▫ N

Any Immunodeficiency ▫ Y ▫ N

Previous Pulmonary or Allergy patient ▫Y ▫ N

Hospitalization/Repeated ED Visits in the last year due to asthma or recurrent wheezing ▫Y ▫ N

Systemic Steriod use > 2 times in the last year ▫Y ▫ N

Any allergy testing, IgE, PFTs, CXR, sinus films, sweat test-please include results ▫ Y ▫ N

Special Needs: Austisc or Develpmental delay , or needs handicapped access ________________________

Referring Primary Care Provider

Referral Date: ________________

Referring PCP: __________________________

Referred By Name):

____

Phone Number: ______________

Best Time to Call: ___________

Fax Number (For Follow Up): ________________

Updated 01/28/18 OG

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: ____________________