CHOC Breathmobile™ Primary Care Provider Referral Form

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

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

Referring Primary Care Provider

Referral Date: _____

Referring PCP: _____

Referred By Name):

_____

Phone Number: _____

Best Time to Call: _____

Fax Number (For Follow Up): _____

Reason for Referral:

Is Child a Breathmobile Patient □Y □ N

Is Child < 37 weeks? □Y □ N

Is Child Diagnosed with Cystic Fibrosis? □Y □ N

Is Child Diagnosed with Complex Heart Disease? □Y □ N

Any Immunodeficiency □ Y □ N

Any previous Pulmonary, 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

Special Needs: Austisc or Develpmental delay □Y □ N

□Other-_____

_____

Patient Information

Child's Name: _____

Date of Birth ____/____/____

Home Address: _____

Apt: ____ City _____ Zip Code _____

Home Phone Number: _____

Mother/Guardian Name: _____

Work/Cell Number: _____

Father/ Guardian Name: _____

Work/Cell Number: _____

Does Child have Health insurance? □ Y □ N

Insurance Type: □ MediCal □ Private/Kaiser □ none

Other_____

Was Authorization processed by Choc Health Alliance:

Auth# _____

Were notes faxed to Breathmobile □Y □ N

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**

Updated 09/22/2016 RMtz