DEPARTMENT OF HEALTH AND HOSPITALS
Asthma Management and Prevention Program

Insert Your Hospital Logo Here

Asthma Discharge Follow-Up Referral Form

This patient was treated and discharged for emergency asthma care from (Insert Hospital Name) and has been recommended for follow-up care to your clinic. Please contact the patient immediately to establish a primary care routine for asthma care and self-management education.

Patient Section: *(Please provide the required information below)*

Name: _____

Phone Number:_____

Do you agree to receive follow-up care for your asthma and give (Insert Hospital Name) permission to refer you to a clinic for follow-up asthma care? ___Yes ___No

Patient Preferred Follow-up Days and Times: *(You can select more than one option)*

Best day(s) of the week: ___Mon. ___Tues. ___Wed. ___Thur. ___Fri.
___Sat.____ Sun

Best time of the day:
___AM (8:30am-10:45am) ___ (11:00am-12:00pm)
___PM (1:00pm-5:00pm) ___ (5:00pm- 9:00pm)

_____ _____
Patient Signature Date

Hospital Use Only

Fax Referral Form to (Insert Clinic Name)
Fax Number: (Insert Fax #)