

# Montana Asthma Program (MAP) Home Visiting

## CONFIDENTIAL REFERRAL FORM

Health Department/Health Center Address City, MT ZIP

Phone (406)\_\_\_\_-\_\_\_\_ Fax (406)\_\_\_\_-\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Person making referral: \_\_\_\_\_

MD/Agency \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Was client or parent informed about this referral?  Yes  No

How did you hear about this program? Newspaper\_\_\_\_ Radio\_\_\_\_ Email/Newsletter\_\_\_\_  
Medical Provider\_\_\_\_ Internet\_\_\_\_ TV news\_\_\_\_ Public Health Dept. \_\_\_\_

### CHILD REFERRAL 0-17 YEARS

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent(s): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Child's SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Insurance: \_\_\_\_\_

Provider: \_\_\_\_\_

Last ED visit/hospitalization/urgent care visit due to asthma (if known): \_\_\_\_/\_\_\_\_/\_\_\_\_

Asthma Control Test (ACT) score (if known): \_\_\_\_ Date of ACT: \_\_\_\_/\_\_\_\_/\_\_\_\_

Concerns about the child's asthma: \_\_\_\_\_

#### ELIGIBILITY:

- Children aged 0-17
- Resident of \_\_\_\_\_ County
- ACT score of less than 20 points
- Frequent asthma symptoms or activity limitations due to asthma  
and/or
- At least one emergency department, urgent care, or hospital visit due to asthma related illness

#### SERVICES PROVIDED:

- 6 contacts with a Public Health Nurse provided over a course of a year
- General asthma education for the child and their family members
- Review of asthma medications
- Assessment of the house to help identify environmental triggers in the home
- Asthma-friendly mattress and pillow-covers