REFERRAL FORM

This program is administered by the Children's Hospital of Philadelphia. Funding is provided by the Pennsylvania Department of Health through a grant from the Centers for Disease Control and Prevention.

To be eligible for home visits child must be between 2 and 16 years of age

_____	____/_____/_____	_____
Name of Child	Date of birth	Age
_____	_____	
Name of Parent/Caregiver	Phone Number	
_____	_____	
Street Address	Zip Code	
_____	_____	
Referral Source	Date of Referral	

To be eligible for CAPP's Home Visiting program, patient must:

① **Live in one of the following counties:**

- ☐ **Philadelphia County**
- ☐ **Delaware County**
- ☐ **Montgomery County**

② **Be on one of these Preventive/Controller Meds:**

Accolate Dulera Alvesco Asmanex Advair
Flovent Qvar Symbicort Pulmicort Singulair Arnuity Breo

③ **And, *in the past year*, have had <u>two</u> ED visits for asthma** OR **<u>one</u> IP admission for asthma**

Number of Emergency Department visits for asthma in the past 12 months

_____ by parent report

_____ by medical record/discharge papers

Number of Inpatient Admissions for asthma in the past 12 months

_____ by parent report

_____ by medical record/discharge papers

REFERRAL FORM

This program is administered by the Children's Hospital of Philadelphia. Funding is provided by the Pennsylvania Department of Health through a grant from the Centers for Disease Control and Prevention.

Patients are ineligible for CAPP's Home Visiting program, if:

1. Does not meet the above criteria
2. Patient has other chronic respiratory illnesses such as cystic fibrosis
3. Patient has cyanotic congenital heart disease

Please email to Secure Address: capp1@email.chop.edu

Or Fax to Confidential Line: 267-426-5774

For office use only:

☐ Eligible for Home Visits – date recorded in log: _____

☐ Not Eligible, Referred to Community Class

Signature of Community Health Worker:_____ Date:_____

Signature of Lead Community Health Worker:_____ Date:_____

Signature of Program Manager:_____ Date:_____