Asthma Care
McClellan Street Health Center
600 McClellan Street
Schenectady, NY 12304
Phone: (518) 347-LUNG (5864)
Fax: (518) 347-5518
Ellismedicine.org

REFERRAL FOR SERVICES

Date of Referral: _____

Patient Information

Name:_____ DOB:_____ Telephone: (H)_____ (W)_____

Address: _____

Referring Provider: _____ Telephone: _____ Fax: _____

Primary Care Provider: _____ Telephone: _____ Fax: _____

Asthma Specialist: _____ Telephone: _____ Fax: _____

Clinical Information: Please complete all clinical information available.

Circle Diagnosis: Asthma

Circle Reason(s) for Referral:

- New Onset Asthma
- Medically Complex Conditions *(unstable asthma)*
- Medically Stable

Spirometry studies:	**Result**	**Date**
FEV1		
FVC		
FEF 25-75		
FVC/FEV1 Ratio		
Peak Flow		

Program Selection: Check program order

☐ **Comprehensive Asthma Education Program:**
(Includes Asthma Self Management Training **and** Medical Therapy)

- Asthma Action Plan
- Asthma Control Testing
- Spirometry, if not on file, recent, or abnormal
- MDI Training with a Spacer

☐ **If Indicated:**

- Smoking Cessation
- Alpha-1 Screening
- NiOx Testing
- Peak Flow Monitoring

Provider Signature (**REQUIRED**) _____**Date**_____

When complete, please FAX referral form to us at: (518) 347-5518
Please be sure to include insurance referral forms or authorizations if necessary

For RT Staff Use: Registration Completed_____ Date of Appointment _____