

Pitt County Memorial Hospital
University Health Systems of Eastern North Carolina

PEDIATRIC ASTHMA PROGRAM
PITT COUNTY REFERRAL FORM

Pediatric Asthma Program
Phone# 252-816-6833
Fax # 252-816-6859

DATE _____ DOB _____

NAME _____ AGE _____

PARENT / GUARDIAN NAME _____

ADDRESS _____

PHONE _____ SCHOOL _____

PREDICTED PEAK FLOW _____ HEIGHT _____

MEDICATION OR ASTHMA ACTION PLAN (Please list or attach)

REFERRED BY _____ PHONE _____

REASON FOR REFERRAL:

- { SOCIAL CONCERNS (financial/insurance, non-compliance with appts, etc.) Please explain.
- { EQUIPMENT NEEDS (spacer, peak flow meter)
- { REINFORCEMENT OF EDUCATION (1-2 visits)
- { CASE MANAGEMENT SERVICES (problematic / complex patients)

OTHER COMMENTS: _____

