Referral Form for Patients with Asthma

Please Print Clearly and Check All That Apply

Referral Criteria

Does the patient have moderate persistent or severe persistent asthma? ☐ YES ☐ NO

Have pests (mice, rats or cockroaches) or mold been observed in the home? ☐ YES ☐ NO ☐ N/A

Does the patient (or patient's guardian, if younger than 18 years old) consent to a home safety visit by HNP staff? ☐ YES ☐ NO

Acceptance of this service is not mandatory. Families can cancel the service at any time. This service is limited to patients living within Cattaraugus County.

FAX or EMAIL the completed form with the subject "Asthma Referral" to:
(716) 701-3744 or tawind@cattco.org

Cattaraugus County HNP staff will contact the family to set up an appointment for a home safety visit after receiving the referral.

Household Information

Patient Name: _____ **Date of Birth:** _____

Address, Apt #: _____ **Zip Code:** _____

Guardian's Name: _____ **Guardian Relationship:** _____

Phone #: _____ **Best time to call:** _____

Email address (optional): _____

Referring Hospital/Clinic Information

Name of Referring Clinic/ Facility: _____

Name of Person Making Referral: _____

Date of Referral: _____

Contact Phone #: _____

Contact Email: _____

Print Name of Treating Physician: _____

Signature of Treating Physician: _____

Additional Comments/Notes/Description of Problem (optional):

Healthy Neighborhoods Program
Cattaraugus County Health Department
One Leo Moss Drive, Suite 4010
Olean, NY 14760
(716) 373-8050
www.cattco.org/healthy-neighborhoods