MCAN Philadelphia Asthma Action Initiative CAPP

REFERRAL SHEET date:______________________

To be eligible child must be between 2 and 17 years of age

______________________	______/________/________	________
Name of Child	Date of birth	Age
______________________	______________________	
Name of Parent/Caregiver	Phone Number	
______________________	______________________	
Street Address		
______________________	______________________	
Zip Code	Referral Source	

To be eligible for the home visits program, patient must**:**

1. Live in one of these zip codes:

West and South Philadelphia zips (11):

19104, 19131, 19139, 19142, 19143, 19151, 19153, 19145, 19146, 19147, 19148

Northwest Philadelphia zips (4):
19120, 19129, 19141, 19144

Lower Northeast zips (3):
19124, 19125, 19134,

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

Accolate	**A**eroBid	**F**lovent	**S**erevent	**V**anceril
Advair	**A**zmacort	**P**ulmicort	**S**ingulair	

3. We would like to know the following information about the patient's hospital visits:

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

PLEASE FAX SHEET TO CONFIDENTIAL CAPP#: **267-426-5774**

For office use only:

☐ Eligible for Home Visit – date of Assessment: ______________________________

☐ Not Eligible, Referred to Community Class

CAPP at CHOP North * 3535 Market Street, Suite 1032
Philadelphia, PA 19104 * 215-590-5261
Revised 5/09/2008