BALTIMORE CITY HEALTH DEPARTMENT

COMMUNITY ASTHMA PROGRAM (CAP)

ASTHMA and HEALTHY HOME VISIT REFERRAL FORM

Your healthcare team would like to refer you to the Baltimore City Health Department's (BCHD's) **Community Asthma Program** so that you can receive follow-up with an offer of asthma home visits to help you manage your child's asthma.

With your permission, we will fax this referral form to BCHD's Asthma Intake Coordinator so that you can be contacted by **BCHD's Community Asthma Program** within the next few days by phone or email.

BCHD offers free home visits to Baltimore City families to help reduce your child's asthma symptoms by providing asthma information and supplies, assessing environmental triggers in the home, and providing information on resources and services with the goal of making your home healthier. These services do not cost you any money.

Referral Date: _____

Clinic/Practice/Hospital/Organization: _____ _____

Person Providing Referral: _____ F ax Number: (_____)_____

Child's Name: (first) _____ (last)_____

Child's Date of Birth: _____

Parent/ Guardian Name: (first) _____ (last) _____

Home Address: _____ Zip Code: _____

Best Contact Number: (_____)_____ ☐cell phone ☐home phone

☐ I agree to share this information with Baltimore City Health Department's Community Asthma Program

Parent/Guardian Signature: _____ Date:_____

PLEASE FAX THIS SIGNED FORM TO BCHD at 410-244-1366

QUESTIONS? CALL BCHD at 410-396-3848