**SUFFOLK COUNTY DEPT. OF HEALTH SERVICES**
**ASTHMA REFERRAL TO PUBLIC HEALTH NURSING**

**Date of Referral**:_____

**Referring Provider**:_____ **Office Contact Source**:_____

**Referring Provider Address**:_____

**Referring Provider Phone Number**: _____**Provider Fax Number**:_____

**HEALTH INSURANCE:** ID#:_____ Type: _____ Health Insurance Phone #: _____

**Responsible Person for Insurance**_____

**Patient Name**:_____**DOB**:_____**Social Security Number**:_____

**Parent/Guardian:**_____ **Phone #**:_____

**Address**:_____

**Primary Dx**.: **Asthma**

**Sec. Dx.:**

**Asthma Action Plan:**

**Health Hx./Other**:

**Followup Appts**:

**Goals**: Optimal knowledge re: nutrition, hydration, age appropriate safety, asthma management, identification of triggers in home, s/s illness, s/s of asthma exacerbation, when to call MD, medications, use and care of peak flow meter spacer and nebulizer if prescribed by MD. Compliance with use of peak flow and use of nebulizer,(if prescribed by MD) medications, MD f/u, Other: _____
Agency policy states that patients and families will be taught their care by the nurse as they deem possible.

□ **SKILLED NURSING** Freq._____ Duration_____

**Skilled Observation**: Physical assessment, cardiopulmonary evaluation, vital signs, weight, monitor nutrition and hydration status; use and care of peak flow meter and nebulizer.

**Teaching:** Nutrition, hydration, age appropriate safety, asthma management, identification of triggers in home, s/s of illness, s/s asthma exacerbation, when to call MD, medications, use and care of peak flow meter spacer and nebulizer,( if prescribed by MD),need to f/u with MD.

**Other:** Referral to community resources as appropriate.

□ **MSW** _____(Specify reason) Freq._____ Duration_____

□**Other**_____ (Specify reason) Freq._____ Duration_____

| **MEDICATION NAME ROUTE** | **DOSAGE** | **FREQ.** | **DRUG ALLERGIES**_____□ **NKA**<br>**□Other**_____<br>**Diet** ____□ **Regular** □**Other** _____<br>**Fluid restrictions** □**None** □**Other** _____<br>**Activity Restrictions:** □**None** □**Bed rest** □**OOB w/BRP only**<br>**Prognosis: :** □**Good** □**Fair** □**Poor** □**Guarded**<br>□**Other (specify)**_____<br>**MEDICAL EQUIP/SUPPLIES** □ **Peak flow meter** □**Nebulizer** □**Spacer** |
|---|---|---|---|

□ **INITIAL HV TO BE MADE WITHIN _____days_____weeks. This patient is under my care and the above health services are authorized by me**

| PHYSICIAN'S NAME AND ADDRESS | PHYSICIAN'S SIGNATURE<br><br>***Please sign and return*** | DATE |
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