ANMED HEALTH

REFERRAL FORM

Asthmania Academy

2000 East Greenville Street, Suite 5100, Anderson, SC 29621
864.512.6626 • Fax 864.512.4468

Date: _____ Patient's Name: _____

Parent/Guardian Name: _____

Address: _____

Phone (home):_____ Phone (other): _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Primary care doctor's name: _____

Primary care doctor's phone number: _____ Fax number: _____

Insurance: _____ Diagnosis: _____

NOTE: Visits include asthma education and an assessment of asthma control/severity including Lung Function Testing (Spirometry) as appropriate per NHLBI Guidelines (EPR-3).

Please check here for:

☐ Evaluation of exercise intolerance - to include an Exercise Provocation Study as appropriate. (Must be able to perform spirometry - usually 6 years or older).

Please list any other concerns that you would like us to address:

_____

_____

_____

Please provide a list of your patient's current asthma medications:

_____

_____

_____

Asthmania Academy reports and recommendations will be sent to the patient's primary care physician and scanned into the patient's medical record at AnMed Health.

Please fax this form and recent office visit notes to (864) 512-4468. We will contact the patient for you or you may call (864) 512-2255 to schedule an appointment (e.g. if the patient is in your office at the time) .

Referring Physician: _____