City and County of San Francisco
DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEALTH

REFERRAL FORM FOR HOME-BASED ENVIRONMENTAL SERVICES FOR PEOPLE WITH ASTHMA IN SAN FRANCISCO

(Must be completed by medical provider; for San Francisco residents only)

Date:_____

Section I

Patient: _____ Medical #: _____
(First Name) (Last Name)

Guardian: _____ Home Phone: _____
(If patient is under 18 years old) (First Name) (Last Name)

Address: _____ Alt. Phone: _____
(Street #) (Street Name) (Apt.#) (Zip)

Primary Language: _____ Best Time To Contact: _____

Primary Care Provider (PCP): _____ Phone: _____Fax:_____

Institution/Address:
_____ E-mail: _____

Referring Provider if other than PCP: _____ Phone: _____Fax:_____

Institution/Address:
_____ E-mail: _____ ❑ Other _____

Section II

Patient's date of birth: _____ Sex: ❑ M ❑ F

Patient has had asthma symptoms during the past 12 months? ❑ Yes ❑ No

Severity per NIH: ❑ Mild Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

Does patient have an asthma home action plan? ❑ Yes ❑ No | Does patient have a peak flow meter? ❑ Yes ❑ No

Types of medications the Patient is currently taking:
Quick relief medication: _____
Long-term control medication: _____
Other: _____

Known or Suspected Triggers:

Animals	❑ Yes	❑ No	❑ Unknown
Cockroaches	❑ Yes	❑ No	❑ Unknown
Dust mites	❑ Yes	❑ No	❑ Unknown
Environmental tobacco smoke	❑ Yes	❑ No	❑ Unknown
Exercise	❑ Yes	❑ No	❑ Unknown
Grass/trees/weeds	❑ Yes	❑ No	❑ Unknown
Mold	❑ Yes	❑ No	❑ Unknown
Stress	❑ Yes	❑ No	❑ Unknown
Upper respiratory infections	❑ Yes	❑ No	❑ Unknown

Other_____

CONCERNS: _____

Please return form to David Lo
Fax: 415-252-3889, or
Email: David.Lo@sfdph.org

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