Referral Form to
School-Based Asthma Therapy (SBAT) Program

Please fax to (614) 355-6227

Today's Date:_____

Provider Contact Information

Referring Provider:

Office:

Referrer (school nurse name):

Office/Provider Telephone: Office/Provider Email:

Patient Demographic Information (as much as you can provide)

Child's name: Child's DOB:

Name of school and district (if known):

Parent/caregiver name:

"Good" Phone Number:

Language (if other than English):

Reason for Child's Referral to SBAT Program (check all that apply)

- Financial concerns
- Frequent ER/hospitalizations
- Frequent school absence related to asthma
- Frequent school clinic visits related to asthma
- Non-compliance with asthma medications
- Re-enrollment in SBAT
- No albuterol at school
- Other (please explain):

Is family willing to speak to us about the program? __Yes ___No
Does the child have an albuterol at school already? ___Yes ___No

For Office Use Only: _____NoCxMed _____No PCP _____Overdue Appt
_____AM routine _____Pt Resistant _____InsProbs

NATIONWIDE CHILDREN'S®
When your child needs a hospital, everything matters.