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

Please fax to SBAT at (614) 355-6227.

Today's Date:_____

School Contact Information

School District: _____

Name of school:_____

Referrer (school nurse name):_____

Nurse Telephone: (___) ___-____ Nurse Email: _____

Patient Demographic Information

Child's name:_____ Child's DOB:_____/____/_____

Child's grade in school:_____

Parent/caregiver name: _____

"Good" Phone Number: (___) ___-____ Language (if other than English): _____

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

- ☐ No asthma provider
- ☐ 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
- ☐ Other _____

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.℠