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

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

Today's Date:____

Patient's Name: _______________________ Patient's DOB: ____ /____ /______

Parent's/Caregiver's Name: ______________________________

Parent's/Caregiver's Phone Number: ______________________

Patient's School: ____

Language (if other than English):_________________________

Physician Name & Contact Info: ___________________________

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

- Financial concerns
- Frequent office appointments related to asthma
- Frequent ER/hospitalizations
- Frequent school absence related to asthma
- Non-compliance with asthma medications
- Re-enrollment in SBAT
- Other: ________________________________

For Office Use Only: ___________ NoCxMed ___________No PCP _____________Overdue Appt

___________ AM routine ________ Pt Resistant ________________ InsProbs