Esperanza
COMMUNITY HOUSING

TO: **Esperanza Community Housing Healthy Breathing Project**

Date: _____

From (**Include Referral Agency Name, Referrer, Phone Number and/or Email Address**):

_____

_____

Patient Name: _____ DOB: _____
If under 18, Parent/Legal Guardian: _____
Phone: (Home)_____(Cell)_____(Work)_____
Street Address: _____
City: _____ Zip Code: _____ Home Language: _____

# of School and/or Work Days Missed Due to Asthma: _____ Hospitalizations:_____
Emergency Room Visits: _____

Current Medications:

Comments:

Are there other family members in the home to be seen?
Name:_____ DOB:_____
Name:_____ DOB:_____

Parent Consents to Referral (ECHC staff will contact patient for appointment):

_____
(Parent signature or Phone Consent Date/Time)

PLEASE SEND ALL REFERRALS TO HEALTHY BREATHING PROJECT MANAGER, AMELIA FAY-BERQUIST, amelia@esperanzacommunityhousing.org OR FAX TO (213) 748-9630 ATTN: HEALTHY BREATHING PROJECT.