# CHESTER HOME VISITING REFERRAL FORM FOR HEALTHCARE PROVIDERS

*This is a program of the Philadelphia Regional Center for Children's Environmental Health, a collaboration between the Children's Hospital of Philadelphia and the Perelman School of Medicine, funded by the National Institute of Environmental Health Sciences (Grant Number: P2CES033428). Additional financial support has been provided by Keystone First.*

*To be eligible for home visits, child must be between 2 and 16 years of age and meet additional criteria as listed below. Submission of this form does not guarantee participation in CAPP's Home Visiting program.*

________________________________ ____/_____/_____ _______

Child's Name Date of birth Age

Child's Gender: ☐ Male ☐ Female ☐ Non-binary

Child's Race, Nationality, or Ethnic Background: ☐ Black/African American ☐ Hispanic ☐ White ☐ Asian ☐ Mixed ☐ Native American ☐ Other ☐ Don't know

________________________________ _(______)______________________

Name of Parent/Caregiver Phone Number

________________________________ ______________________________

Street Address Zip Code

Best time to contact parent/caregiver: ☐ Morning ☐ Early Afternoon ☐ Late Afternoon ☐ Evening

________________________________ ________________________________

Referral Source Date of Referral

Did you speak with the child's caregiver to let them know a CAPP team member will be contacting them with additional information? ☐ Yes ☐ No

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## To be eligible for CAPP's Home Visiting program in Chester, patient must:

① **Live in one of the following ZIP code(s):** ☐19013 ☐19014 ☐19015 ☐19016 ☐19022 ☐19061

② **Be on one of these Preventive/Controller Medicines (please select):**

☐ Accolate ☐ Dulera ☐ Alvesco ☐ Asmanex ☐ Advair ☐ Arnuity

☐ Flovent ☐ Qvar ☐ Symbicort ☐ Pulmicort ☐ Singulair ☐ Breo

③ **And, *in the past year*, have had at least <u>one</u> oral steroid AND/OR <u>one</u> ED visit AND/OR <u>one</u> inpatient visit <u>FOR ASTHMA:</u>**

| | |
|---|---|
| Number of Emergency Department visits for asthma in the past 12 months | _______ by parent report<br>_______ by medical record/discharge papers |
| Number of Inpatient Admissions for asthma in the past 12 months | _______ by parent report<br>_______ by medical record/discharge papers |
| Name(s) of oral corticosteroid for asthma flare and number of prescriptions in the past 12 months | Steroid name(s): ______________________________<br>_______ by medical record/discharge papers |

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**Patients are ineligible for CAPP's Home Visiting program if:**

1. The above criteria are not met, OR
2. Patient has other chronic respiratory illnesses such as cystic fibrosis, OR
3. Patient has cyanotic congenital heart disease

**Please Email to Secure Address: capp1@chop.edu**

**Or Fax to Confidential Line: 267-426-5774**

For office use only:

☐ Eligible for Home Visits – date recorded in log: ___________________________

☐ Not eligible for Home Visits, referred to Community Class

Signature of Community Health Worker:___________________________ Date:__________________

Signature of Lead Community Health Worker:______________________ Date:__________________

Signature of Program Manager:___________________________________ Date:__________________