INDOOR AIR QUALITY REFERRAL FORM

Provider, please fill out form below legibly and email to
kiran@lungsrus.org **and** vivian@lungsrus.org or fax to 408-998-0578

Referring Provider

Name:____ **Phone #:**________________

Organization: ____

Diagnosis: _______________________________________

Are you currently using a (Spacer or Peak Flow Meter): _____________________________

Patient Name:____ **Patient DOB:**___________

Parent/Guardian name (if patient under 18): __________________________________

What Medical Provider are you with (or private practice)? ___________________________

Does the patient have a MediCal Insurance plan: ( ) Yes ( ) No

If yes, which plan:_________________________________
Plan member # if known: ____________________________

Patient/Parent Primary Language: ____________________

<u>Patient contact information</u>
Home phone: ___________________________ **Cell phone:** _____________________

Address: ____**City:** ___________________

Email:________________________________

For more information, please contact:
Kiran Kaur and Vivian Chang at 408 -998-5865 or email at kiran@lungsrus.org/ vivian@lungsrus.org