ORANGE COUNTY
HEALTH DEPARTMENT

Healthy Homes Fax Referral

Fax : 919-644-3328

Please confirm receipt: 919-245-2379

The Health Department will provide a **free** in-home assessment to help identify indoor asthma triggers and other housing-related health hazards.

Our goal is to improve the health and quality of life for children with asthma by improving the indoor air quality and safety of their home environment. The purpose of a Healthy Homes visit is to identify potential asthma triggers and health hazards in a home, educate the parents and caregivers on steps they can take, and provide resources to assist in the control of those hazards.

REFERRING ORGANIZATION **Date Fax Sent: _____/_____/_____**

Person making referral (check one): □ School Nurse □ Medical Provider □ ED Navigator □ CC4C Nurse

Name: _____ Organization: _____

Phone: _____ Fax: _____

To receive a participant's Assessment Report, you must be a HIPAA-Covered Entity

I am a HIPAA-Covered Entity (check one) □ Yes □ No □ Don't Know

Check if you do NOT want to receive an Assessment Report. □

PATIENT

Patient Name: _____ Date of Birth:_____

Patient's Parent/Guardian:_____

Phone Number: _____ Back-up Number:_____

Street (Apt):_____

City, State, Zip:_____

Language Preference: □ English □ Spanish □ Other:_____

Patient's School (if applicable):_____

Insurance: □ Medicaid □ Private □ None □ Other:_____

I give permission to share this information about my child with the health department and its partners, which may include nurses from the school, UNC Health Care, or Medicaid (as appropriate) and a Family Success Alliance Zone Navigator, so they can contact me to conduct a home visit.

Doy permiso para que se comparta esta información sobre mi niño/a con el departamento de salud y sus asociados, lo cual puede incluir a enfermeras de la escuela,
UNC Health Care o Medicaid (según sea apropiado) y Navegantes de Zona con la Alianza del Éxito Familiar, para que se puedan comunicar conmigo y lleven a cabo una visita a mi hogar.

PROGRAM ELIGIBILITY

The Healthy Homes serves patients 0-17 years old that live in Orange County and meet **at least one of the following criteria**. Please indicate which criteria this patient meets (check all that apply):

- ☐ Poorly-controlled persistent asthma, as diagnosed by a medical provider or identified by a school nurse
- ☐ Hospital admission for asthma exacerbation in past 12 mo.
- ☐ Repeated ED or urgent care visits for asthma within past 6 mo.
- ☐ Overuse of rescue medication in last 6 mo.
- ☐ More than one course of oral steroids in last 6 mo.

Parent/Guardian Signature:_____ Date:_____

If no signature above, check the appropriate box below:

□ *Parent/guardian is not available to sign the referral form, but is aware of the referral*

□ *Parent/guardian is not aware they are being referred, but I believe they would benefit from it*

Note: Please acquire authorization from parent/guardian if possible. Lack of a signature above may delay services.

Signature of person making referral:_____ Date:_____