TOWN OF STRATFORD

Birdseye Municipal Complex, 468 Birdseye Street, Stratford, CT 06615
Phone: 203-385-4090 • Fax: 203-381-2048
www.townofstratford.com

Health
Department

Putting On AIRS

PHYSICIAN REFERRAL FORM

Today's Date: ____________________

PATIENT INFORMATION

Patient Name: ____ DOB: ________________________

Parent/Guardian Name: ____

Address (Street/City/Zip): ____

Phone Number: Home ________________ Cell _________________

Diagnosis of Asthma in past 12 months ☐ **Diagnosis of Asthma over 1 year ago** ☐

Have you discussed this Putting on AIRS referral with the patient? YES NO

Comments on condition of patient:

Medications/Dosage

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REFERRAL SOURCE

Physician Name: ____________________________ Name of Practice: ____________________________

Address (Street/City/Zip): ____

Phone Number: _______________________________ Fax: _____________________________________

PLEASE FAX THIS FORM TO:
Putting on AIRS
Attn: Greta Roberts, Coordinator
(203) 381-2048

For information or questions regarding this program please call the Stratford Health Department at
(203) 385-4090

Thank you for your participation in this program!