

**Gateway Health Plan
Asthma and Cardiac Referral Fax Form**



Please fax this information to the Gateway Health Plan Confidential server at (412) 255-5639

Date _____ Member name _____

Physician _____ GHP ID# _____

MD Phone number _____ Member phone number (_____) _____

Asthma "AIR" Gateway Asthma Program

Is this a new diagnosis of Asthma? Yes No

If NO, how long has the member been an asthmatic? _____

Is the member a diabetic? Yes No

Name of pulmonologist or allergist _____

Does the member have: (check all that apply)

- Peak flow meter Nebulizer
 Spacer Written Asthma Action Plan

Current asthma medications: _____

Cardiac Help Your Heart Cardiac Program

What cardiac condition has been diagnosed? (Check all that apply)

- CHF (EF _____%) MI (Date of MI _____) CAD HTN

Is the member a diabetic? Yes No

Name of Cardiologist _____

Name of Endocrinologist _____

Contraindication to ACE _____

Contraindication to Beta blocker _____

Current cardiac medications: _____

The member would benefit from: (check all that apply)

- Referral to "AIR" Gateway Asthma Disease Management Program Mailing of educational material
 Referral to Help Your Heart Cardiac Disease Management Program Home Care referral
 Referral to Healthy Returns Diabetes Program Other
 Goal of Home Health

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