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? _____

Name/number of pulmonologist or allergist _____

Does the member have: (check **all** that apply)

_____ Spacer _____ Nebulizer

_____ Written Asthma Action Plan

Did the member have spirometry testing? ____Yes ____No

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/ARB _____

Contraindication to Beta blocker _____

Current cardiac medications: _____

_____

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

____ Referral to "*AIR*" Gateway℠ Asthma Disease Management Program

____ Referral to Help Your Heart Cardiac Disease Management Program

____ Home Health Referral

Goal of Home Health?: _____

____ Other_____

____ Mailing of educational material

____ Referral to Healthy Returns Diabetes Program

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