

**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<sup>SM</sup> 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 <sup>SM</sup> Asthma Disease Management Program | ___ Mailing of educational material              |
| ___ Referral to Help Your Heart Cardiac Disease Management Program            | ___ Referral to Healthy Returns Diabetes Program |
| ___ Home Health Referral  |  |
| Goal of Home Health?: _____   |  |
| ___ Other _____   |  |
| _____   |  |
| _____   |  |

DM-013-0905

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