**Provider Order for Asthma Preventive Services:   
Asthma Self-Management Education and/or In-Home Environmental Trigger Assessment**

Member name:

Member date of birth:

Member Medi-Cal number:

Recommended service(s):

Asthma Self-Management Education

Provider attestation:

* I attest that the above-identified member has an asthma diagnosis

In-home Environmental Trigger Assessment

Provider attestation:

* I attest that the above-identified member’s medical record indicates poorly controlled asthma [defined as 1) having a score of 19 or lower on the Asthma Control Test or 2) an asthma-related emergency department visit or hospitalization or two sick or urgent care asthma-related visits in the past 12 months] OR the member has my recommendation as a licensed physician, nurse practitioner, or physician assistant.

Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical provider name, degree, and licensing number:

Date authorized: