



## Breathe Easy COPD & Asthma Program Enrollment Form

Please complete all fields and answer all questions

### Member Information

Member Name \_\_\_\_\_

Member ID \_\_\_\_\_

Member Phone \_\_\_\_\_

Member E-mail \_\_\_\_\_

Member Date of Birth \_\_\_\_\_

### Provider Information

Name of Current Primary Care Physician \_\_\_\_\_

Name of PCP's Group \_\_\_\_\_

Name of Current Pulmonologist \_\_\_\_\_  
(If any, if known)

Name of Pulmonology Group \_\_\_\_\_  
(if applicable, if known)

Other Specialist \_\_\_\_\_  
(Relating to COPD/Asthma)

Other Specialist Group \_\_\_\_\_  
(if applicable, if known)

### Member History

Have you had a pulmonary function test/flow spirometry test within the last year?

NO YES If yes, date of test: \_\_\_\_\_

Have you ever been hospitalized for asthma/COPD? NO YES

If yes, when? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever been placed on a ventilator? NO YES

Have you ever been on oxygen? NO YES

If yes, how long?

Do you currently use an inhaler(s)? NO YES

More than one inhaler? NO YES

Please email completed form to [advocates@wellhealthqc.com](mailto:advocates@wellhealthqc.com)

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For Internal Use Only

Received by \_\_\_\_\_ Date Received \_\_\_\_\_ Provider \_\_\_\_\_ Follow  
Up Notes \_\_\_\_\_