



Physician Referral 2025

Please print clearly

Physician Name _____

Patient Name _____ Date of Birth _____

Date Last Seen _____

Current Medications _____

“Normal” Peak Flow Rate: _____

Asthma is: _____ Mild Intermittent _____ Mild Persistent

_____ Moderate Persistent _____ Severe Persistent

Primary Allergies _____

Other Significant Medical Conditions _____

Although Camp Wheez is medically supervised, your patient will continue to be under your direct medical care.

I would like the above-named patient to be enrolled in Camp Wheez. All breathing and exercise training is to be geared to the patient’s capabilities.

Physician Signature

Date

Print Name

Phone

Address, City, State, Zip Code

Forms are due by July 14, 2025

Email to: campwheez@sansumclinic.org

Mail to: Sansum Clinic - Camp Wheez, PO BOX 1200, Santa Barbara, CA 93102-1200
Call with any questions or to confirm your referral form has been received: (805) 681-1793