NYC Health
Center for Health Equity

New York City Department of Health and Mental Hygiene

Citywide Asthma Initiative - IPM Program

IPM Referral Form

Client Name

Parent Name

Address

APT#

NYCHA Y ☐ N ☐

Borough

Zip Code

Telephone #

Appointment Date

Time

Target Area
- ☐ Kitchen
- ☐ Bathroom
- ☐ Bedroom
- ☐ Other

Pest
- ☐ Roaches
- ☐ Other

Please E-mail this form to ipm@health.nyc.gov

Referral Name and Organization

Date