Health Education Referral Form

Complete sections A-C.

Fax to 714-560-5280

A. PATIENT INFORMATION

Please verify patient's current address and phone number.			
Name:			Date of referral:
BSC Promise Member ID #:			Phone number:
DOB:	Bio Sex: ☐M ☐F	Language: ☐E ☐S ☐Other:	☐Other:
Address:			Zip Code:
If patient is a minor, please provide name and language of parent/legal guardian.			
Name:		Language: ☐E ☐S ☐Other:	
Notes:			

B. SERVICE REQUESTED (select all that apply)

☐ class ☐ one-to-one counseling ☐ health education material ☐ support group

Topic				
	☐ Age-Specific Ant. Guidance **	☐CKD	☐Immunizations	☐Physical Activity
	☐ Asthma	☐COPD	☐Injury Prevention	☐Stress Management
	☐Complimentary & Alternative Medicine	☐Diabetes	☐Nutrition	☐Substance Abuse
	☐Breastfeeding	☐Family Planning	☐Obesity	☐Tobacco Cessation
	☐ Chronic HF	☐HIV/STD Prevention	☐Parenting	☐Unintended Pregnancy
	☐Cholesterol	☐Hypertension	☐Perinatal/Pregnancy	☐Other:
	** **including information that children can be harmed by exposure to lead**			

C. PROVIDER INFORMATION

Provider name:	
Person completing referral (if other then provider):	
Phone number:	Fax Number:

Population Health Management Programs use only:	
Referral Outcome	
Provider Notification Date:	