



## Clinical Health Promotion Program Referral Form

Thank you for referring your patient(s) to our Healthy Families Program. This program offers families of members who are ages 7 to 17 assistance with leading a healthy lifestyle and reducing childhood obesity. Our team helps each member by providing education, community resources, and an individualized plan of care over a six-month period. All information contained on this form is strictly confidential and may become part of your patient's record.

<b>Referring physician information</b>	
Referring physician's name:	
Referring physician's phone:	
Referring physician's email:	
<b>Member information</b>	
Member name:	
Referral date:	State member ID:
Member DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/guardian phone:	
Parent/guardian email:	
Reason for referral to Healthy Families Program (program offered to children and teens ages 7 to 17): <input type="checkbox"/> Healthy living/nutrition <input type="checkbox"/> Weight management	
<b>Member information</b>	
Member name:	
Referral date:	State member ID:
Member DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/guardian phone:	
Parent/guardian email:	
Reason for referral to Healthy Families Program (program offered to children and teens ages 7 to 17): <input type="checkbox"/> Healthy living/nutrition <input type="checkbox"/> Weight management	
<b>Member information</b>	
Member name:	
Referral date:	State member ID:
Member DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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