



**Community Based Lifestyle Change Programs  
Referral Form**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Insurance: \_\_\_\_\_

Weight Management **BMI** \_\_\_\_\_

Diabetes Prevention Program  
(Group Lifestyle Balance Class)

*Provide at least **one** of the following:*

**Hemoglobin A1c** \_\_\_\_\_

**Fasting plasma glucose test** \_\_\_\_\_

**Oral glucose tolerance test** \_\_\_\_\_

Hypertension Class Series  
(Blood Pressure Self-Monitoring, DASH Diet and Exercise)

Tobacco Cessation

**Provider Name:** \_\_\_\_\_

**Office Phone Number:** \_\_\_\_\_

**Fax to: (509) 232-8151**

**No attachments necessary**

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