

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) 319-2352

No attachments necessary

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