Providence

FAX (509) 319-2352
Wellness.WA@providence.org

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