



Individual's Name: Preferred Name: Parent/Guardian Name:	Date: MRN:
Wellness Program(s): Prediabetes Family Program/Smart Moves Diabetes ReCHARGE (Self-Management & Education Program) Healthier Eating: Cooking Classes Hypertension Physical Activity	Comments:
Food Farmacy Program (Central New Mexico PHS and PHP only) Food Farmacy (If referral is ONLY for Food Farmacy, please send via secure email to chwellnessreferrals@phs.org) (Community Health CHWs: please create a referral in Epic for Food Farmacy)	

Individual's Demographics			Known Transportation Issues	
Address:	Zip Code:	Phone:		
DOB:	Gender:	Email:		
Race/Ethnicity				
American Indian/Native American	White/Caucasian	Asian/Pacific Islander	Black/African	
Hispanic, Latino or of Spanish origin		Other:		
Preferred Language			Spanish Speaking Class Requested	
Spanish English Other:			Yes No	
Insurance (please mark ALL that apply)				
Medicaid Medicare Self-Pay Other:				
BlueCross BlueShield United Healthcare Molina Healthcare Presbyterian Health Plan				
Individual's or Parent/Guardian Signed Consent — <i>Persona o Padre/Guardián Firmaron un Consentimiento</i>				
I understand and agree that Presbyterian Community Health will contact me about free community health programs, and will inform the person referring me to Presbyterian Community Health about my participation.				
<i>Entiendo y acepto que Presbyterian Community Health se va a contactar conmigo acerca de programas de salud libres de costo en la comunidad, y Presbyterian Community Health le informará a la persona que me refiere de mi participación.</i>				
Initials of referring person for verbal consent:				

Referring Provider Location/Type:	
Referring Provider Name:	Email:
Phone:	
Date sent:	
I would like feedback on my patient/member participation via email: YES NO	
<ul style="list-style-type: none"> For ALL referrals, fax completed referral form to (505) 291-2912 or send via secure email to chwellnessreferrals@phs.org. 	

For general questions that do not contain protected health information (PHI), please email chwellnessreferrals@phs.org or call (505) 923-5963 or 1-888-320-1762. ****Per HIPAA standards, ANY email that contains PHI must be encrypted.****