PRESBYTERIAN
Community Health

Referral for Wellness

Individual's Name:
Preferred Name:
Parent/Guardian Name:

Date:

MRN:

Wellness Program(s): ☐ Chronic Disease Self-Management Program (general chronic disease)
☐ Chronic Pain Self-Management Program ☐ Diabetes Self-Management Program
☐ Cancer: Thriving & Surviving ☐ Diabetes ReCHARGE (DSMES)
☐ National Diabetes Prevention Program/for Prediabetes
☐ 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 ☐ English ☐ Other:

Spanish Speaking Class Requested

☐ 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 — *Persona o Padre/Guardián Firmaron un Consentimiento*

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.
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 participació.

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

- 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.****