CalOptima Health

Health and Wellness Referral Form

Member Information

Member Name: _____ **Member CIN #:** _____

Current Address: _____ **City:** _____ **Zip:** _____

Current Phone: _____ **2nd Phone :** _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐ Male ☐ Female ☐ Other

Parent/Caregiver/Guardian Name: _____

Language(s): ☐ Arabic ☐ Chinese ☐ English ☐ Farsi ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Other:

Referral Reason: *Select 1 only. Attach labs and/or progress notes from the last 30 days*

☐ Prediabetes (**A1C: 5.7 to 6.5%**)

☐ Diabetes **A1C:** _____ ☐ Type 1 ☐ Type 2

☐ Gestational Diabetes

ICD-10 code(s): _____

☐ Weight:

- ☐ **Date of Calculation:** _____
- ☐ **Height (inches):**_____ ☐ **Weight (pounds):** _____
- ☐ **BMI:** _____ ☐ **BMI %:** _____

☐ Other referral reason not listed (specify):

☐ Asthma

☐ Cholesterol

☐ Chronic Kidney Disease (CKD)

☐ Chronic Obstructive Pulmonary Disorder (COPD)

☐ Congestive Heart Failure (CHF)

☐ Depression

☐ Exercise/Fitness

☐ Heart-Related Conditions

☐ Hypertension (HTN)

☐ Nutrition (Specify topic): _____

☐ Tobacco Cessation

Known Comorbidities: _____

Barriers/Needs: ☐ Behavioral health ☐ Cognitive ☐ Family/Caregiver support ☐ Food insecurity ☐ Hearing ☐ Housing ☐ Physical ☐ Vision ☐ Transportation ☐ Other (specify): _____

Instructions/Comments: _____

REQUIRED: Provider Information

Provider Name:	**Provider NPI #:**
Provider Address:	**City:** **Zip:**
Provider Phone #:	**Provider Fax #:**
Office Contact:	**Phone:**
Provider Signature:	**Date:**
Office stamp	

Please attach labs and/or progress notes from the last 30 days.

Fax form to **714-338-3127** or email to **healthpromotions@caloptima.org.** For questions call **888-587-8088.**

For a copy of this form, visit **www.caloptima.org/healtheducation**

Please note: All emails that contain PHI must be sent in an encrypted method using a DHCS-approved method.