CalOptima
A Public Agency
Better. Together.

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 past 30 days*

☐ Prediabetes (**A1C: 5.7 to 6.5%**)

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

☐ Gestational Diabetes

ICD10 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 Disease (COPD)

☐ Congestive Heart Failure (CHF)

☐ Depression

☐ Exercise/Fitness

☐ Heart-Related Conditions

☐ Hypertension (HTN)

☐ Nutrition (Specify topic): _____

☐ Tobacco Cessation

Known Co-Morbidities: _____

Barriers/Needs: ☐ Behavioral Health ☐ Cognitive ☐ Family/Caregiver Support ☐ Food Insecurity ☐ Hearing ☐ Housing Insecurity ☐ 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 past 30 days.

Fax: **1-714-338-3127**; Email: **healthpromotions@caloptima.org**; Questions: **1-714-246-8895**

Download the form: **www.caloptima.org/healtheducation**

Please note: All emails that contain PHI must be sent in an encrypted method using a DHCS approved solution. Rev: 01/2020