CalOptima
A Public Agency
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Health Management Department Referral Form

Fax to: **1-714-338-3127** or Email to: healthpromotions@caloptima.org
For printable health education materials, visit www.caloptima.org/healtheducation
Call for questions: **1-714-246-8895**

Member Information

Date: _____ **Health Network**: _____ ☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE

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

Caregiver Name (if applicable)**:** _____ **Gender:** ☐ M ☐ F **Age:** _____ **DOB:** _____

Address: _____ **City:** _____ **ZIP:** _____

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

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

Service Requested

Referral Topic(s): *(provide labs and/or progress notes as applicable)*

☐ Asthma
☐ Congestive Heart Failure
☐ COPD
☐ Diabetes
☐ Hypertension
☐ Medical Nutrition Therapy (MNT)*
☐ Prenatal/Family Planning
☐ Tobacco Cessation
☐ Weight Management
☐ Other (please specify):

_____

***MNT excludes support for oral, enteral and parenteral nutrition**

Prioritize reason for referral, with 1 as most important

1. _____ 2. _____ 3. _____

Referral Comments: _____

_____

_____

Barriers faced by the member (*if known*)**:**

☐ Behavioral health ☐ Family/Caregiver support ☐ Food insecurity ☐ Housing ☐ Transportation
☐ Other (please specify): _____

_____

_____

Additional Information for Weight Management

Date of Calculation: **BMI:** **BMI%:** **Weight (lbs.):** **Height (in.):**

REQUIRED: Referring Provider Information

Provider Name: _____ **Provider NPI #:** _____

Provider Address: _____ **City:** _____ **ZIP:** _____

Provider Phone: _____ **Provider Fax:** _____

Office Contact: _____ **Phone:** _____

Provider Signature: _____ **Date:** _____

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