



Health Education Referral Form

MMG/Direct Providers Only
FOR OFFICE USE ONLY

Referral No. _____

To refer a Molina member for health education services:

1. Complete all requested information (please print clearly).
2. Fax or E-mail the completed referral form to Molina at (562) 901-1176 or MHI Health Education Mailbox
3. Fax required documentation with all referrals.
4. If you have questions, call 800-526-8196, Ext. 127532.

Today's date: _____

Member Information

Last Name:	First Name:	Member ID/ CIN #:
Address:	City:	Zip Code:
Current Phone #:	Preferred Language:	DOB:
Diagnosis:		
Full Name of Guardian (if member is under 18 years of age):		
Best Time to Call Member:	OK to leave messages at home:	YES NO

PCP Information

Name:	MMG#:
Address:	
Phone Number:	Ext: Fax Number:

Educational Need (check one only)

<input type="checkbox"/> COPD* <input type="checkbox"/> CVD* (Cardiovascular Disease): Coronary Artery Disease, Congestive Heart Failure, High Blood Pressure <input type="checkbox"/> Diabetes* *Attach: Recent Progress Notes and Labs	<input type="checkbox"/> Asthma <input type="checkbox"/> Cholesterol* <input type="checkbox"/> Nutrition (General)	<input type="checkbox"/> Injury Prevention <input type="checkbox"/> Healthy Baby (Infant Safety/Car Seat) <input type="checkbox"/> Pregnancy EDC: _____	<input type="checkbox"/> Smoking Cessation <input type="checkbox"/> Stress Management <input type="checkbox"/> Women's Health <input type="checkbox"/> Exercise <input type="checkbox"/> Family Planning <input type="checkbox"/> STD's
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Weight Control*

Pediatric Weight Management (ages 16 and below)
Attach: Recent Progress Notes and Growth Charts

Weight Management (Weight Watchers® program, ages 17 and older only)
Height: _____ Weight: _____ BMI: _____

For a BMI of 40 or higher (obesity class III), it is Molina's policy that the referral contain a signed medical release (physically able to exercise) for the member to participate in the Weight Watchers® Program.

"OK to participate in the Weight Watchers® program:" _____

Physician Signature _____ Date _____

MEDICAL NUTRITION THERAPY (Consultation with Registered Dietitian)

For all MNT referrals, PLEASE attach most recent progress notes and labs

<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Nutrition Assessment (specify need):
<input type="checkbox"/> Liver Failure	<input type="checkbox"/> Oncology	<input type="checkbox"/> Other:
<input type="checkbox"/> Multiple Food Allergies	<input type="checkbox"/> Renal Failure	