MOLINA HEALTHCARE

FOR OFFICE USE ONLY
Referral No.

HEALTH EDUCATION REFERRAL FORM

MMG/Direct Providers Only

To refer a Molina member for health education services:

1) **Complete all requested information (please print clearly).**
2) Fax the completed referral form to Molina at (562) 901-1176.
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)

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

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

☐ Failure to Thrive	☐ HIV/AIDS	☐ Nutrition Assessment (specify need:
☐ Liver Failure	☐ Oncology	☐ Other:
☐ Multiple Food Allergies	☐ Renal Failure	