MOLINA HEALTHCARE

FOR OFFICE USE ONLY
Referral No.

# HEALTH EDUCATION REFERRAL FORM
## IPA/Medical Group

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) 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: | IPA/Medical Group Name: | |
| Address: | | |
| Phone Number: ( ) | Ext: | Fax Number: ( ) |

## EDUCATIONAL NEED (check one only)

**Attach: Recent Progress Notes and Labs**

- ☐ COPD
- ☐ CVD (Cardiovascular Disease): Coronary Artery Disease, Congestive Heart Failure, High Blood Pressure
- ☐ Diabetes Program (ages 18 and over)

☐ Asthma Program

☐ Smoking Cessation Program

☐ Healthy Baby Program (infant safety and convertible car seat for infants 2 to 18 months of age)

☐ Pregnancy Program **EDC: _____**

☐ Pediatric Weight Kits (ages 16 and below)

☐ 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 contains 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**

**Do not write below this line. For Health Education Department use only.**