



## Health Education Referral Form

Fax to (951) 280-8218

### A. PATIENT INFORMATION

Please verify patient's current address and phone number.			
Name:			Date of referral:
DOB:	Sex: <input type="checkbox"/> <input type="checkbox"/>	Language: <input type="checkbox"/> <input type="checkbox"/>	
Address:			
City:	Zip code:	Phone number:	
<i>If patient is a minor, please provide name and language of parent/legal guardian.</i>			
Name:			Language: <input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> Other:
Diagnosis (include ICD-10 code) / Notes:			

### B. SERVICE REQUESTED

<input type="checkbox"/> Class <input type="checkbox"/> Support group <input type="checkbox"/> One-to-one counseling* <input type="checkbox"/> Health education material				
<b>Topic</b>	<input type="checkbox"/> Age-Specific Ant. Guidance	<input type="checkbox"/> Family Planning	<input type="checkbox"/> Lead Poisoning	<input type="checkbox"/> Obesity
	<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV/STD Prevention	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Tobacco Cessation
	<input type="checkbox"/> Breastfeeding	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Parenting	<input type="checkbox"/> Substance Abuse
	<input type="checkbox"/> Dental	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Perinatal/Pregnancy	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Injury Prevention	<input type="checkbox"/> Physical Activity	

### C. PROVIDER INFORMATION

Provider name:	
Person completing referral (if other than provider):	
Phone number:	Fax number:

Vantage Medical Group Health Education use only	
<b>Referral Outcome</b>	
Provider notification date:	