Healthcare Practitioner Referral Form

Send to: **Utah Department of Health** Fax: **(801) 323-1577**

PATIENT INFORMATION

Patient's First Name	Patient's Last Name	Patient's Phone

PRACTITIONER INFORMATION

Physician/NP/PA First Name	Physician/NP/PA Last Name	Title (MD, RN, PA, etc.)
Clinic Name	**Clinic Contact First Name**	**Clinic Contact Last Name**
Phone	**Fax**	**Email**
Street Address	**City**	**Zip**

REFERRAL

Check the box(es) of the programs you would like to refer to:

- ☐ Arthritis Foundation Exercise Program
- ☐ Asthma Home Visiting Program *(offered only in Salt Lake and Utah Counties)*
- ☐ BeWise/WISEWOMAN *(cardiovascular risk screening for women)*
- ☐ Breast & Cervical Cancer Screening
- ☐ Diabetes Self-Management Education
- ☐ Enhance Fitness
- ☐ Living Well with Chronic Conditions (CDSMP)
- ☐ Living Well with Chronic Pain (CPSMP)
- ☐ Living Well with Diabetes (DSMP)
- ☐ National Diabetes Prevention Program (Prediabetes)
- ☐ Otago
- ☐ Stepping On (falls prevention)
- ☐ Tai Chi for Arthritis
- ☐ Tobacco Quit Line (1-800-QUIT-NOW)
- ☐ Walk With Ease

ENROLLMENT AGREEMENT

By signing below, I signify the following:

*I am an **enrolled provider** with the Utah Department of Health, Bureau of Health Promotion, Health Resource Center.*
*I have obtained **patient consent** for the requested referral for additional program services.*

Signature _____ Date _____

UTAH DEPARTMENT OF HEALTH

Revised: 3/8/2018