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 Diabetes (DSMP)
- ☐ National Diabetes Prevention Program (Prediabetes)
- ☐ Tobacco Quit Line (1-800-QUIT-NOW)
- ☐ Stepping On (falls prevention)
- ☐ 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: 08/02/2016