

**Telephonic Health Education Referral Form**



**Complete all requested information** (please print clearly).

**Today’s Date**:

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| --- |
| **Member Information** |
| **Last Name**:  | **First Name**:  | **Member ID/ CIN#:**  |
| **Address**:  | **City/State**:  | **Zip Code**:  |
| **Current Phone#:**  | **Preferred Language**:  | **DOB**:  |
| **Diagnosis**:  |
| **Full Name of Guardian** (if member is under 18 years of age):  |
| **PCP Information** |
| **Name**:  |
| **Address**:  | **City/State**:  | **Zip Code**:  |
| **Phone Number:**   | **Ext:**  | **Fax Number:**  |
| **Referral for Educational Services** |
| To refer a Molina member for the following health education services:1. Fax or E-mail the completed referral form to Molina at 1 (800) 642-3691 or MHIHealthEducationMailbox@MolinaHealthCare.Com
2. Fax required documentation with all referrals.
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| **Case Manager Outreach for:** | **Health Educator Outreach for**: |
| [ ]  Asthma (2+ years old)[ ]  COPD (35+ years old)[ ]  Depression (18+ years old)[ ]  Diabetes (18+ years old) | [ ]  Hypertension (18+ years old)[ ]  Heart Failure (18+ years old) | [ ]  Smoking Cessation (18+ years old) [ ]  Adult Weight Management (18+ years old):  |
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| **Medical Nutrition Therapy (Consultation with Registered Dietitian)**For all MNT referrals, please attach most recent progress notes and labs |
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| **Condition:** | **Requested Labs:** | **Other:**   |
| [ ]  Diabetes | A1c, Lipid | [ ]  Nutrition Assessment (specify need/goals):  |
| [ ]  Heart Failure | Chem 10, Lipid |
| [ ]  High Blood Pressure / Coronary Heart Disease | Chem 10, Lipid |
| [ ]  Multiple Food Allergies | Allergy Testing |
| [ ]  Renal Disease (Not on dialysis) | Chem 10, GFR |
| [ ]  Unintentional Weight Loss | Chem 10 |
| **For additional health education questions, please email us @** **MHIHealthEducationMailbox@MolinaHealthCare.Com****or call 1 (866) 891-2320 ext. 751136 option 2** |
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