Healthy Weight for Life
Initial Referral Form

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

Instructions ***(Please print clearly):***

- Use this form to refer eligible **Alliance children ages 2-18** whose BMI is ≥ **85th** percentile.
- Payment is subject to member eligibility; please verify current eligibility prior to providing services.
  Note: Providers will only get reimbursed for the initial referral and six month follow up.
- Fill out referral form completely (incomplete forms will not be processed). Please review, reinforce, and modify as necessary the ***"Healthy Weight for Life ~ Rx"*** form and give a copy to the patient.
- Fax this completed referral form to: **877-793-8504.**

Provider name:_____ Practice NPI: _____

Provider phone:_____ Fax: _____

Patient name: _____ Alliance ID#: _____

Patient phone #:_____ Date of birth:_____ Gender: ☐ Male ☐ Female

Does the patient have any of the following comorbidities? (*Please check all that apply*)

☐ Pre-diabetes ☐ Diabetes ☐ ≥3 BMI percentile point increase within the last 6 months

☐ Sleep apnea ☐ Other risk factors: _____

Body Mass Index (BMI) Assessment:

Date of Service	Age at Time of Measurement	Height in Inches	Weight in Pounds	(BMI) Value	BMI Percentile According to Growth Chart
		_____ Inches	_____ Pounds		_____ Percentile

The following areas were covered during today's visit:

☐ I have counseled the patient regarding **healthy food choices** and portion sizes

☐ I have counseled the patient regarding regular **physical activity**

☐ I have counseled the patient regarding the Alliance's ***Healthy Weight for Life*** program

☐ I have given the patient the "***Healthy Weight for Life ~ Rx***" form

Physician/patient comments:

_____ _____

Provider signature Date signed

Note: Please complete and give the "Healthy Weight for Life ~ Rx" form to the patient

Healthy Weight for Life ~ Rx

Patient's Name:_____ Date:_____

Your doctor cares about your health. The "5210" goals below can help you improve your health one day at a time.

5 Eat at least **5** fruits and vegetables each day (fresh or frozen are best).

2 Limit screen time to **2** hours or less each day (TV, video games, computers).

1 Be active at least **1** hour each day (walk, ride a bike, play sports, etc).

0 Drink **0** sodas or sweet drinks each day (such as sweet tea, sports drinks, etc.).

You might not be ready to make all of these changes at once. Which changes are you ready to make *now* to be more healthy?

5 Eat at least _____ fruits and vegetables each **day**.

2 Limit screen time to _____ hours or less each **day**.

1 Be active for at least _____ minutes each **day**.

0 Drink no more than _____ sodas or sweet drinks each **week**.

_____ _____

Patient or Parent / Guardian Signature Date

_____ _____

Doctor / Health Care Provider Signature Date

Please give a copy of this form to the patient and keep a copy in the patient's chart. (Please do not fax this form to the Alliance.)

To learn more about the Alliance's ***Healthy Weight for Life*** program, call the Health Education Line at **1-800-700-3874, ext. 5580** or go to www.ccah-alliance.org and click on "Members."