

BETTER CHOICES, BETTER HEALTH

FAX REFERRAL

Please complete the following and fax to _____ at _____.
Attn: _____

Date: _____

Patient Information

*Patients Name (Please Print):	Sex:	Date of birth: (mm/dd/yyyy)
*Patients Phone Number:		
Patients Email:		
*Referring Health Care Provider:		
Chronic Condition(s):		
Would you like us to contact you after your patient has or has not been scheduled for a Better Choices, Better Health workshop? If yes, please provide your contact information. YES, Contact information: _____		
Additional Comments:		

PLEASE NO MEDICAL OR INSURANCE RECORDS

*Required

Questions regarding the Better Choices, Better Health program? Please contact
_____ at _____.