Living Healthy PATIENT REFERRAL

I recommend (Patient Name) ________________________________
enroll in a Living Healthy workshop.

Practice Name ________________________________

Provider Name ________________________________

Phone Number ___________________________ Date __________

For a patient living with any chronic disease, please refer them to a
Living Healthy workshop for help. For pre-diabetic patients, complete
other side and fax to (607) 962-9755.

Your healthcare provider is referring you for enrollment in a Living
Healthy workshop. We offer a variety of classes to help you manage
your health. For more information on which of our workshops is
right for you and what classes are offered in your area, please call
the number listed below.

To register Monday - Friday, 8:00am - 5:00pm, call
1 (877) 496-2780
Or just register online at
https://ceacw.org/find-a-workshop
National Diabetes Prevention Program ONLY

Patient Name __________________________________________

Provider Name __________________________________________

Phone Number ___________________________ Date __________

Pre-diabetes Test Results (Check one and/or enter value):
  O History of gestational diabetes.
  O 2-hour Plasma Glucose (OGTT) ______ mg/dL (Must be 140 - 199)
  O Hemoglobin A1C ________ % (Must be 5.7% - 6.4%)
  O Fasting Plasma Glucose (FPG) ______ mg/dL (Must be 100 - 125)

Additional Information:
Patient’s Height _______ (in)   Weight _______________ (lbs)
BMI _______________ (kg/m2)   Date of Birth __________

I hereby authorize __________________________________________
to share my diagnostic information pertaining to the
abovementioned programs with the S2AY Rural Health Network’s
Living Healthy partners.

Signature: __________________________________________

Please fax this referral to: 1 (607) 962-9755