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