CalOptima
A Public Agency
Better. Together.

Health Education and Disease Management Department Referral Form

Fax form to: **1-714-338-3127** or Email to: **healthpromotions@caloptima.org**
Call for questions: **1-714-246-8895**
For printable health education materials, visit www.caloptima.org

CalOptima Member Information

Date: _____ **Health Network**: _____ ☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE

Member Name: _____ **Member CIN #:** _____

Caregiver Name (if applicable)**:** _____ **Sex:** ☐ **M** ☐ **F** **Age:** _____ **DOB:** _____

Address: _____ **City:** _____ **ZIP:** _____

Phone #: _____ **2nd Phone #:** _____

Language: ☐ Arabic ☐English ☐Farsi ☐Korean ☐Spanish ☐Vietnamese ☐Traditional Chinese ☐Other:_____

Referral Details

Reason for Referral: *(provide labs and/or progress notes as applicable)*

☐ Weight Control***** (see below)
☐ Asthma
☐ Congestive Heart Failure
☐ COPD
☐ Diabetes
☐ Hypertension
☐ Nutrition
☐ Prenatal/Family Planning
☐ Tobacco Cessation
☐ Other (please specify):_____

Prioritize reason for referral, with 1 as most important

1. _____ 2. _____ 3. _____

Service Requested: (*Department **does not support** Medical Nutrition Therapy or Eating Disorders*)

☐ Coaching on general health information
☐ Advanced coaching on nutrition related to complications with chronic conditions
Has the member been informed of this referral to Health Education? ☐ **Yes** ☐ **No**

*Additional Required Information for Child Weight Control (ages 2–18 years only)

Date of BMI Calculation: **BMI:** **BMI%:** **Weight (lbs.):** **Height (in.):**

Primary Diagnosis Code:

☐ E66.01 Morbid (severe) obesity due to excess calories
☐ E66.9 Obesity, Unspecified
☐ E66.09 Other obesity due to excess calories
☐ E66.3 Overweight
☐ Other: _____

Secondary Diagnosis Code:

☐ Z68.53 BMI pediatric, 85th to less than 95th percentile for age
☐ Z68.54 BMI pediatric, greater than or equal to 95th percentile for age

List ICD-10 code(s) of other conditions that may be related to obesity.

_____
_____

Provider Comments on Areas of Focus for the Member

Potential barriers to achieving health goals faced by the member: ☐ Transportation ☐ Family/Caregiver support ☐ Housing
☐ Behavioral health ☐ Food insecurity ☐ Other (please specify): _____

Comments: _____

_____

_____

Referring Provider Information (Required)

Provider Name: _____ **Provider NPI #:** _____

Provider Address: _____ **City:** _____ **ZIP:** _____

Provider Phone #: _____ **Provider Fax #:** _____

Office Contact: _____ **Phone:** _____

Provider Signature: _____ **Date:** _____

Please note: All emails that contain PHI must be sent in an encrypted method using a DHCS approved solution.