WELLNESS PROGRAM/PATIENT REFERRAL FORM

(CONGESTIVE HEART FALIURE, DIABETES, ASTHMA, HYPERTENSION)

CONFIDENTIAL

NAME: ____

MEMBER # ____

AGE: ____

PHYSICIAN: ____

PAST MEDICAL HISTORY: ____

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**You may fax typed office visit reports in lieu of full completion of referral form.

ALLERGIES: ____

MEDICATIONS: ____

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LAST DR. APPT: ____

Fax from: ______________________

Dr. Office: ______________________

Date of Referral: ______________________

Fax to: Wellness Nurse

Gateway Health Alliance

Fax Number: (434) 799-4397

GATEWAY PHONE: (434) 799-0702 Option 5