Clinical Health Promotion Program Referral Form

Washington | Medicaid

Thank you for referring your patient(s) to our Healthy Families program. This program offers families of members who are ages 7 to 17 assistance with leading a healthy lifestyle and reducing childhood obesity. Our team helps each member by providing education, community resources, and an individualized plan of care over a six-month period. All information contained on this form is strictly confidential and may become part of your patient's record.

Referring physician information	
Referring physician's name:	
Referring physician's phone:	
Referring physician's email:	
Member information	
Member name:	
Referral date:	State member ID:
Member DOB:	Gender: ☐ Male ☐ Female
Parent/guardian phone:	
Parent/guardian email:	
Reason for referral to Healthy Families (program offered to children and teens ages 7 to 17): ☐ Healthy living/nutrition ☐ Weight management	
Member information	
Member name:	
Referral date:	State member ID:
Member DOB:	Gender: ☐ Male ☐ Female
Parent/guardian phone:	
Parent/guardian email:	
Reason for referral to Healthy Families (program offered to children and teens ages 7 to 17): ☐ Healthy living/nutrition ☐ Weight management	
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Additional comments
Email this form to Condition-Care-Provider-Referrals@wellpoint.com.

For more information about the Clinical Health Promotion Program, visit **Condition Care**.