

Physician Referral FAX Form

ConnectionsSM Health Management Program Health Coaches are available 24 hours a day/365 days a year to provide education and support to your patients who have chronic conditions or need education on any health care topic.

Patient information

Patient name _____ Gender _____ Member ID # _____

Date of birth _____ Phone – day _____ Phone – evening _____

Preferred day and time to call _____

Reason for referral

Condition

- asthma
- COPD
- coronary heart disease
- diabetes
- GERD
- heart failure
- hypertension
- migraine
- PUD

Decision-support topics

- atrial fibrillation
- back pain (herniated disc, spinal stenosis)
- chronic kidney disease
- chronic pain
- depression

- gynecological conditions
- metabolic syndrome
- prostate condition
- weight loss surgery/obesity
- other _____

Type of support

- adherence to treatment plan
- education
- medication persistence
- behavioral health
- nutrition/lifestyle changes
- treatment options (including Shared Decision-Making[®] videos where available)
- understanding symptom response plans
- additional instructions: _____

Referring physician

Physician last name _____ Physician first name _____

Physician address _____ Phone _____

City _____ State _____ Zip _____ IBC Provider # _____

Date of referral _____ Name of person completing form _____ FAX _____

To refer a patient for Health Coaching, please complete this form and
FAX it to the Connections Health Management Program at **1-800-276-3075**.

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