Gold Coast Health Plan℠
A Public Entity

HEALTH EDUCATION REFERRAL FORM

Please fax to 805-437-5134
HealthEducation@goldchp.org

PATIENT INFORMATION

Member Last Name _____ First Name _____ MI _____ Date of Birth _____

Member ID Number _____ Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Secondary Phone Number _____

REFERRAL INFORMATION

Treating Physician Name _____ Phone Number _____ Fax Number _____

PCP Name _____ Phone Number _____ Fax Number _____

REASON(S) FOR REFERRAL TO GOLD COAST HEALTH PLAN HEALTH EDUCATOR

- ☐ Diabetes
- ☐ Asthma
- ☐ Morbid Obesity Adult (18+)
- ☐ Morbid Obesity (Age 0-17)
- ☐ High Risk OB
- ☐ Psychosocial factors presenting barriers to care
- ☐ Depression
- ☐ Other _____

CLINICAL INFORMATION (To be completed by treating physician or office staff)

_____

_____

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Name and Title of Person Completing Form _____ Phone Number _____ Date _____