



## DISEASE MANAGEMENT PROGRAM PROVIDER REFERRAL FORM

### MEMBER INFORMATION

Member's Full Name

Member's Date of Birth

Member's Preferred Phone Number

Member's CIN Number

### REFERRAL INFORMATION

Your Name

Your Contact Information

Date of Referral

### CHECK ALL BOXES THAT APPLY

- Asthma
- Diabetes Type 1
- Diabetes Type 2
- Pre-Diabetes

Member has needs related to:

- Education about the condition
- Self-management
- Medication adherence
- New diagnosis

### COMMENTS

**Thank you for your referral. Please send the completed form via fax to 1-855-883-1552 or email to [DM@goldchp.org](mailto:DM@goldchp.org).**  
If you have any questions, please call the Disease Management Department at 1-805-437-5694.