Pediatric Wellness Program Referral Form

This service is offered free of charge. The $300 cost is underwritten by Monterey Salinas Healthcare Collaborative Diabietes Initiative

Patient's legal name: _____ Date of birth: _____
Last First MM/DD/YYYY

Primary contact: _____ Relationship: _____
Last First

Phone number: _____ Email: _____

Address: _____

Gender: ☐ male ☐ female Preferred language: ☐ English ☐ Spanish Preferred location: ☐ Monterey ☐ Salinas

Central California Alliance for Health member: ☐ Yes ☐ No

Other insurance coverage:_____ Member ID: _____

Reason for referral: ☐ >85th percentile / age BMI ☐ unexpected weight gain ☐ Other: _____
☐ abnormal laboratory values: _____

Please list current: BMI _____ BMI/age percentile:_____

Referral for:
☑ Comprehensive pediatric wellness coach services
☐ Group education class series
☐ 1:1 wellness coaching visits

Referring Provider: _____
Name (Please print)

Provider Signature: _____
Signature Date

Please fax completed form to (831) 644-7453 or send secure email to PediWellnessCoach@chipm.org.
For more information, please call (831) 644-7491.

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