Tools for Better Health Chronic Disease Self-Management Program

Patient Referral Form

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____/_____/_____ **Gender:** ☐ Male ☐ Female

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Best phone number to reach you: _____

Best time of day to contact you: _____

May we leave a message? ☐ Yes ☐ No

Language: ☐ English ☐ Spanish ☐ Other (specify) _____

I understand that information regarding my participation in the Tools for Better Health workshops will be shared with my health care provider.

Patient Signature _____ **Date** _____

PROVIDER INFORMATION

Provider name: _____ **Email:** _____

Clinic: _____

Address: _____

Phone: _____ **Fax:** _____

Fax recommendations to 785-843-3161.
Questions? Contact Michael Showalter at 785-856-5340 or mshowalter@ldchealth.org.

LAWRENCE-DOUGLAS COUNTY Health Department