

Clinical Health Promotion Program Referral Form

Thank you for referring your patient(s) to our Healthy Families Program. This program offers families of members who are ages 7 to 17 assistance with leading a healthy lifestyle and reducing childhood obesity. Our team helps each member by providing education, community resources, and an individualized plan of care over a six-month period. All information contained on this form is strictly confidential and may become part of your patient's record.

Referring physician information		
Referring physician's name:		
Referring physician's phone:		
Referring physician's email:		
Member information		
Member name:		
Referral date:	State member ID:	
Member DOB:	Gender: □ Male □ Female	
Parent/guardian phone:		
Parent/guardian email:		
Reason for referral to Healthy Families Program (program offered to children and teens ages 7 to		
17): ☐ Healthy living/nutrition ☐ Weight management		
Member information		
Member name:		
Referral date:	State member ID:	
Member DOB:	Gender: □ Male □ Female	
Parent/guardian phone:		
Parent/guardian email:		
Reason for referral to Healthy Families Program (program offered to children and teens ages 7 to		
17): ☐ Healthy living/nutrition ☐ Weight management		
Member information		
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17): ☐ Healthy living/nutrition ☐ Weight management		

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Member information		
Member name:		
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Additional comments		
Email this form to Condition-Care-Provider-Referrals@healthybluela.com.		

For more information about the Clinical Health Promotion Program, visit our website Disease Management | Healthy Blue Louisiana (healthybluela.com).