BETTER CHOICES, BETTER HEALTH® SD SUITE OF PROGRAMS FAX REFERRAL FORM

Betterchoicesbetterhealthsd.org | 1-888-484-3800

*Note: Patient must give written consent for BCBH® SD to call Health Professional

Please FAX this completed form to 1-605-928-4429

This fax form is for healthcare offices to refer a client/patient to the Better Choices, Better Health® SD (BCBH) suite of evidence-based programs designed for those with chronic health conditions. These FREE 6-week workshops help people with chronic conditions and their caregivers manage their physical and mental health wellness.

REFERRING PROVIDER/CLINIC/PRACTICE INFORMATION

Clinic/Organization Name: _____

Healthcare Provider(s): _____

Primary office contact for fax referral clarification: _____

Fax #: _____ Phone: _____ Email: _____

CLIENT/PATIENT IFORMATION

Name: _____ DOB: ____/_____/_____

Address: _____ City: _____ Zip: _____

1st Phone: _____ 2nd Phone: _____

Client/Patient is being referred because:

- ❑ They have a chronic health condition
- ❑ They are at risk for a chronic health condition
- ❑ They're a caregiver for someone with a chronic health condition

PARTICIPATION

If the BCBH program cannot reach you by phone, is it ok to leave a message?

- ❑ Yes
- ❑ No

Best time to reach you: **Day of week:** M - T - W - Th - F **Time:** ___ AM ___ PM ___ Anytime

- ❑ I agree to have the BCBH Program tell my health care provider(s) that I registered to attend a BCBH workshop and provide them with the results of my participation.

Which of the following Self-Management Programs workshops are of interest to you?

- ❑ Chronic Disease (CDSMP)
- ❑ Diabetes (DSMP)
- ❑ Chronic Pain (CPSMP)
- ❑ Chronic Disease for Worksites
- ❑ Online Chronic Disease Self-Management Program (digital CDSMP)

Client/Patient Signature: _____ **Date:** _____/_____/_____

Verbal Consent obtained by: ❑ Clinic staff_____ ❑ Referral Director_____ ❑ Other_____

Health Professional: Please FAX this completed form to 1-605-928-4429

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