



Referral to Optum Health Enhancement Please fax completed form to: 408-937-3638

All fields need to be completed.

Patient Information															
First Name:				Las	Last Name:										
Gender: Male		Male	□ Female DOB:			'			Dx (ICD.10):						
Mailing Address:									-						
City:						State:			Zip Code:						
Phone Number:						Seco			condary Phone Number:						
Email ad	ss:										!				
Insuranc	e:							Group #:							
Referring	g Pro	ovider I	Name:												
Referring Provider Phone Number:					r:		Fax No			x Number:					
Adult Group Classes (≥ 18 years)															
Referral to:								Program Criteria:							
□ Healthier You (English□ Healthier You (Spanish)□ Healthier You (Vietnamese)							 BMI ≥ 25; or BP > 120/80; or A1c < 6.4; or T. Chol ≥ 200; or TG ≥ 150 								
□ Renal Program (English) □ Renal Program (Spanish)							□ GFR 30-59 □ GFR 15-29 □ GFR <15								
□ Living with COPD (English)□ Living with COPD (Spanish)□ Living with COPD (Vietnamese)							Newly dx, recently hospitalized; never received education								
 □ Living with Diabetes (English) □ Living with Diabetes (Spanish) □ Living with Diabetes (Vietnamese) 							A1c <u>></u>	6.5,	type 2 diab	etes	A1c:				

Optum		PHYSICIANS MEDICAL GROUP
□ Exercise Program (English)□ Exercise Program (Spanish)□ Exercise Program (Vietnamese)	 □ Stable health conditions □ Followed by PCP Requirements: □ Working PC or laptop □ Webcam □ Internet/email access 	OF SAN JOSE

Any questions, please call 1-800-335-3362.