Prescription for Health Referral Form

Patient Name _____ County of Residence _____

Phone number _____ Email _____

Patient is availability: ☐ Morning ☐ Noon ☐ Evening (mark all that apply)

Reason for Participating:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart Disease
- ☐ Overweight
- ☐ Pregnancy
- ☐ Food access issues
- ☐ Nutrition education
- ☐ Other: _____

Patient Goals:

Over the next 6 weeks I will:

- ☐ Improve fasting blood sugar to _____ mg/dL
- ☐ Lose _____ pounds (up to 15 pounds)
- ☐ Improve blood pressure to _____ mm/Hg
- ☐ Other: _____

I will do this by:

- ☐ Eating ___ cups of fruits and vegetables each day
- ☐ Eat ___ cups of fruits and vegetables each day in place of _____
- ☐ Exercise _____ minutes each week
- ☐ Other: _____

Primary Care Physician: _____

Address: _____

Authorizing Signature: _____ Date: _____

Please send referral form to:

PFH Staff Only

Received by: _____ Date: _____

Form sent to MSUE on: _____

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