

RETURN TO: Arizona Living Well Institute

Chronic Disease Self-Management Program: Healthy Living (CDSMP)

Fax: 1-480-288-8261 Email: referral@azlwi.org

DATE: ____/____/____

FAX BACK #: (____) ____ - ____
Referred by: _____
Location/Site: _____
Address: _____
City: _____
Zip: _____
Phone: (____) ____ - ____

<input type="checkbox"/> Area Agency on Aging	<input type="checkbox"/> Housing/Residential
<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Physician Office
<input type="checkbox"/> Home Visiting	<input type="checkbox"/> Senior Center
<input type="checkbox"/> Health Start / NICP	<input type="checkbox"/> Veterans Administration
<input type="checkbox"/> Hospital	<input type="checkbox"/> Worksite

Consent and Personal Information Section:

I understand that the Arizona Living Well Institute and/or one of its partners will be contacting me with information on the Healthy Living: Self-Management of Chronic Conditions workshops. My participation is voluntary. I understand that any information I provide will be kept confidential. I give the Arizona Living Well Institute and the referring agency or physician permission to discuss my use of this service.

_____	(____) ____ - ____
Name of Person Referred (please print)	Phone: <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> cell
_____	____/____/____
Email	Date of Birth
_____	_____
Signature of Person Referred	City of Residence

Verbal consent received

_____	_____
Name (print)	Signature
<i>Person obtaining verbal consent</i>	

Spanish Speaker English Speaker

Best time to call:

8am-12pm

12pm-5pm

Specific: _____

Comments: _____

