

Our Pathways to Health Referral

Community Health Alliance of Humboldt-Del Norte, Inc.

Please complete the following and fax to:

Michelle Comeau, Pathways Operations Officer at (707) 445-2854

Date:

Patient Information

Patient Name (Please Print): _____	Sex: M <input type="radio"/> F <input type="radio"/>	Date of Birth: (mm/dd/yyyy) □ / □ / □
Patient Phone Number: _____		
Chronic Condition <input type="radio"/> Diabetes <input type="radio"/> Hypertension <input type="radio"/> Arthritis <input type="radio"/> Obesity <input type="radio"/> Caregiver <input type="radio"/> Other: _____		
Referring Health Care Provider: _____		
Would you like the Community Health Alliance to contact you after your patient has been scheduled for a Our Pathways to Health workshop? <input type="radio"/> Yes <input type="radio"/> No		
Contact Number: _____		

Additional Comments:

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