

Wyoming Healthy Together Referral Form



Commit to your health.

Please complete the referral information below and fax it to **1-888-245-1928**, or you can call **1-888-545-1710**. Client information is kept confidential.

Wyoming Healthy Together Client (Patient)

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone Number(s): _____

DOB: _____

Parent or Guardian Name: _____

Medicaid Number: _____

Primary DX: _____

Reason for referral to program:

- Client needs education (disease, treatment plan)
- Reinforce medication and/or treatment compliance
- Provide links to community resources
- Assist coordination of care and/or services
- Weight Management program
- Language, literacy barrier
- Missed appointment(s)
- Maternal/Prenatal support: EDC__ Grav__ Para__
- Other: _____

Facility/Provider Information

Name: _____

Referring staff name: _____

Facility/Office: _____

Address: _____

Phone: _____

Fax: _____

Primary Care Physician: _____

Primary Mental Health Provider (if applicable):

Follow-up instructions for Healthy Together Staff

I would like clinical updates:

Patient information (progress notes after each contact)

When there are changes or concerns

Other special follow-up information requested:

Wyoming Healthy Together use only

Date Received _____ Opened _____ Deferred _____ HC _____