The following documentation has been submitted to ASTHO for the Accreditation Library as a potential example of Health Department documentation that might meet the PHAB Standard and Measure. This document is not intended to be a template, but is a reference as state health agencies develop and select accreditation documentation specific to the health department's activities.

Please note that the inclusion of documentation in this library does not indicate official approval or acceptance by PHAB.

<table>
<thead>
<tr>
<th><strong>Document Title:</strong></th>
<th>Arizona Living Well Institute, Chronic Disease Self-Management Program: Healthy Living (CDSMP) – Referral Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Document Date:</strong></td>
<td>1/14/13</td>
</tr>
<tr>
<td><strong>Version of Standards and Measures Used:</strong></td>
<td>V1.0</td>
</tr>
<tr>
<td><strong>Related PHAB Standard and Measure Number</strong></td>
<td><strong>Domain:</strong> 7  <strong>Standard:</strong> 2  <strong>Measure:</strong> 2  <strong>Required Documentation:</strong> 1</td>
</tr>
<tr>
<td><strong>Short description of how this document meets the Standard and Measure’s requirements:</strong></td>
<td>The Arizona Living Well Institute Referral Form documents collaborative implementation of chronic disease referrals from ADHS home visiting programs to the Arizona Living Well Institute. Referrals help link adults with chronic disease to local chronic disease self-management programs.</td>
</tr>
<tr>
<td><strong>Submitting Agency:</strong></td>
<td>Arizona Department of Health Services</td>
</tr>
<tr>
<td><strong>Staff Contact Name:</strong></td>
<td>Sheila Sjolander</td>
</tr>
<tr>
<td><strong>Staff Contact Position:</strong></td>
<td>Assistant Director</td>
</tr>
<tr>
<td><strong>Staff Contact Email:</strong></td>
<td><a href="mailto:Sheila.sjolander@azdhs.gov">Sheila.sjolander@azdhs.gov</a></td>
</tr>
<tr>
<td><strong>Staff Contact Phone:</strong></td>
<td>602.542.2818</td>
</tr>
</tbody>
</table>
RETURN TO: Arizona Living Well Institute  
Chronic Disease Self-Management Program: Healthy Living (CDSMP)  
Fax: 1-480-288-8261  Email: referral@azlwi.org

DATE: __/__/____  

☐ Area Agency on Aging  ☐ Housing/Residential  
☐ Behavioral Health  ☐ Other: ____________________  
☐ Community Health Center  ☐ Physician Office  
☐ Home Visiting  ☐ Senior Center  
☐ Health Start / NICP  ☐ Veterans Administration  
☐ Hospital  ☐ Worksite

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

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: ☐ home  ☐ work  ☐ cell  
_________________________________________  / _____ / _____
Email  
Date of Birth  
_________________________________________  
Signature of Person Referred  
City of Residence  

☐ Verbal consent received  

_________________________________________  Name (print)  
Person obtaining verbal consent  
Signature

☐ Spanish Speaker  ☐ English Speaker

Best time to call:
☐ 8am-12pm
☐ 12pm-5pm
☐ Specific: ________________

Comments: _______________________________________________________
_____________________________________________________
_____________________________________________________
_____________________________________________________
_____________________________________________________