



**Diabetes and Cardiovascular Health Program**  
**Healthcare Referral Form**

**Send online to:**  
[Rhode Island Diabetes and Cardiovascular Health Network Referral Form](#)

**Person Making Referral - Contact Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title:  Healthcare Professional  Community Health Worker  Other: \_\_\_\_\_

Phone: \_\_\_\_\_ and/or Email: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Office Name: \_\_\_\_\_

Organization Type:  Healthcare Provider  Community-Based Organization  Other: \_\_\_\_\_

**Making a Referral For - Patient Contact Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone (required): \_\_\_\_\_ Email: \_\_\_\_\_

Patient's preferred Language:  English  Spanish  Other: \_\_\_\_\_

**Evidence-based Program Referral** - These programs are at no cost to the patient.

**Ready for Health** – a diabetes prevention program (formerly National DPP)  
*1 hour per week, 16 weeks; followed by 6 months of follow-up Virtual and In-Person*

Trained Lifestyle coaches help participants lower their risk of getting type 2 Diabetes by eating healthier, increasing physical activity, and losing weight. **This program is for adults who are pre-diabetic and at high risk of developing type 2 diabetes.**



**Healthy Heart Ambassador Blood Pressure Self-Monitoring with Coaching**  
*10-minute personalized 1-on-1 meetings twice monthly, 1-hour monthly group nutrition seminars, 4 months*

Trained Coaches teach **adults with high blood pressure** how to accurately measure their own blood pressure and encourages them to use this skill to communicate with their physician to better manage their health. Participants receive blood pressure cuffs and tracking tools to monitor blood pressure at home.



*Referrers have acquired written consent from the patient to make a referral to RIDOH on their behalf, for RIDOH to share the patient's contact information with the delivery organization, and for the delivery organization to contact the patient. The disclosure of information is for the purpose of the patient being referred to a chronic disease education/self-management program.*

Referrer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For questions email [Rosa.Leon.CTR@health.ri.gov](mailto:Rosa.Leon.CTR@health.ri.gov) or call 401-603-8414.

**Thank you for your referral and for supporting your patient in taking this step!**

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