Health Plan of San Joaquin

Community Health Education and Engagement Referral (CHEER) Form

UM Department Fax No.: (209) 942-6302

Date: _____

Referral From: ☐ Provider ☐ Member

Member's Name: _____ DOB: _____

HPSJ ID #: _____ Telephone #: _____

Language: _____ Ethnicity: _____

Provider's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____

Referring Person / Department: _____

Telephone #: _____

Patient Information:

___ ___ / ___ ___ / ___ ___
Birthdate (MM/DD/YY)

Reason for referral / diagnosis(es):

_____

_____

Referral for:

- ☐ **Health Education Classes**
- ☐ **Case Management**
- ☐ **Disease Management (Diabetes, Asthma, Congestive Heart Failure)**
- ☐ **Other resources:** _____