MAC
Maintaining Active Citizens
Your Area Agency on Aging

REFERRAL TO Living Well Evidence-Based Self-Management Workshops

These workshops will provide your patients with the skills and knowledge to better manage their chronic conditions. With their permission, a 3-month action plan and goal will be shared with you at the end of the workshop.

Patient Name: _____

Gender: ☐ MALE ☐ FEMALE

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Chronic conditions_____

Most recent BP if hypertensive_____ Most recent A1C if diabetic _____

Living Well Workshops

Refer patient to these programs	**Self-Management Workshop**	**Date Contacted**	**Date enrolled**	**Workshop completed**	**Physician notified of enrollment**	**Physician notified of completion and patient goal**
	Hypertension					
	Chronic Disease					
	Walk with Ease : **Arthritis**					
	Cancer Thriving and Surviving					
	Diabetes					
	Diabetes Prevention Program **Pre-Diabetes)**					
	Depression: PEARLS					
	Falls: Stepping On Falls Prevention					
	Spanish Diabetes					
	Exercise: Enhance Fitness					
	Exercise: Tai Chi Moving for Better Balance					
	Exercise: Power Up **(Parkinson's)**					

Referred By: _____

Phone _____ Fax number: _____ E-mail_____

Send referral to: Jill Kenney @ 443-859-8509 (FAX)
Or email jak@macinc.org