MUNSON MEDICAL CENTER

MUNSON HEALTHCARE

Greetings!

Thank you for your interest in the Comprehensive Weight Management Program. We commend you for taking an active role on the improvement of your health! You are about to embark on one of the most positive journeys of your life, not to mention an incredible learning experience.

Please complete the enclosed questionnaires in addition to keeping a 3-7 day food and exercise log. In order for us to properly assess your specific needs and desires, it is important to be completely honest when completing the questionnaires. If you have trouble answering or are confused by any questions, please indicate so and answer the question to the best of your ability.

You will be scheduled for initial evaluation appointments with a Registered Dietician, Behavioral Health Specialist and an Exercise Specialist upon receipt of this completed packet, your physician's referral to the program, and a pre-authorization letter from your insurance company (for Priority Health Insurance only). Enclosed is a self-addressed envelope in which to return the enclosed forms. If you printed this packet from the internet, our mailing address is:

Healthy Weight Center
Munson Medical Center
1105 Sixth Street
Traverse City, MI 49684

Please note that we must receive these questionnaires prior to the scheduling of any appointments.

We do require an initial payment equivalent to half of your total estimated out-of-pocket cost at the time you are accepted into the program. You will then be asked to make payments each month so that the remainder of your account balance is paid in full by the time you graduate from the program. Munson employees may pay via payroll deduction.

Should you need to cancel or reschedule any appointment, 24-hours notice is required.

If you have any questions or concerns regarding the program, please feel free to call. We look forward to working with you.

Sarah Wetmore, M.A., CES
Coordinator
Healthy Weight Center
(231) 935-8533 (phone)
(231) 935-8609 (fax)

MUNSON MEDICAL CENTER
Healthy Weight Center

Registration Form Patient Initials: ____________

In order for us to process your registration form quickly and accurately, please print legibly and be sure to complete the entire form. If you have questions please ask for assistance.

(circle one)
Mr. Ms. Mrs. Dr. First Name: ______________________ MI: ____ Last Name: _________________________

(circle one)
Male | Female DOB: ____/____/__________ E-Mail Address: _____________________________________

Address (include apartment or unit #):____

City: ____ State (Province): __________________________

Zip (Postal Code): _________________ Country: ____

Home Phone (include area code): ___________________________ Other Phone: ___________________________

Primary Insurance: ____________________________ Secondary Insurance: ____________________________

Primary Physician: _________________________________ Physician Phone: ___________________________

For which Healthy Weight Center program are you registering? (please check one):

- ☐ Working Off Weight (W.O.W.) – 4 month program
- ☐ Comprehensive Weight Management – 6 month program

*In order to have access to the web site and program support features you must select a unique username and password, as well as a reminder question and answer in case you lose your password. Your **Username** can contain letters and numbers only (no special characters) and your **Password** should not be something easily guessed (but something easily remembered).*

***NOTE** – To use betterMD.net, please disable any pop-up blockers and change your email/spam filter settings to accept important email from betterMD.net and MMHWC staff messages. Contact us if you need help with this.*

Username: __________________________________ Password: ___________________________

Choose one of the following **Reminder Questions** by placing a checkmark in the appropriate box:

- ☐ What is your mother's maiden name?
- ☐ What was the name of your first pet?
- ☐ Whom do you most admire?
- ☐ What elementary school did you attend?

Record your answer here: ____

In accordance with the NOTICE OF PRIVACY PRACTICES that you previously read and signed at Munson Medical Healthy Weight Center (MMHWC), this notice informs you that the MMHWC will share the information contained in this document and other information gathered during your participation in the Weight Management Program with the company betterMD.net, Inc. By signing below you are indicating that you previously read the above stated notice and are fully aware of, and will allow, the sharing of your weight management related information with betterMD.net, Inc.

Signature: ____ Date: ____________________

Form MMHWC registration 20070124.1

MUNSON MEDICAL CENTER
Healthy Weight Center

Enrollment Form Patient Initials: _____________

In order for us to process your enrollment form quickly and accurately, please print legibly and be sure to complete the entire form prior to the orientation meeting. If you are unsure of what to do please ask for assistance from a staff member at the orientation.

First Name: ________________________ Last Name: ________________________ DOB: ____/____/____

What was your weight at age 18? ________ Highest adult weight? ________ Lowest adult weight? ________

If you could weigh whatever you wanted, what would your "dream weight" be? ________

At what weight do you feel you would be happy? _______ What weight would be "acceptable" to you? ______

At what weight (less than your current weight) would you still be disappointed? ________

What weight do you have in mind to achieve as your "goal weight" through this program? ________

Please indicate which weight loss medications you have used in the past (check all that apply):

- ☐ Phentermine
- ☐ Fenfluramine
- ☐ Dexfenfluramine
- ☐ Phen/Fen combination
- ☐ Meridia®
- ☐ Xenical®
- ☐ Wellbutrin
- ☐ Other (list): ______________________
- ☐ None

Are you pregnant? ☐ Yes ☐ No ☐ NA Are you planning a pregnancy in the near future? ☐ Yes ☐ No ☐ NA

Are you currently breast feeding (lactating)? ☐ Yes ☐ No ☐ NA

Indicate which of the following conditions you have suffered or currently suffer from (choose all that apply):

- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Valvular Disease
- ☐ Neurological Disease
- ☐ Bowel Disease
- ☐ Kidney Disease
- ☐ NASH (fatty liver)
- ☐ Liver Disease (severe)
- ☐ Cancer (list types below)
- ☐ High Blood Pressure
- ☐ Osteoarthritis
- ☐ Sleep Apnea
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Thyroid Disease
- ☐ Depression
- ☐ Anemia
- ☐ Gout
- ☐ PCOS
- ☐ GERD (acid reflux)
- ☐ Fibromyalgia
- ☐ Other (list types below)
- ☐ None

Other diseases or illnesses: ___________________________

Types of cancer: ___________________________________

Smoking? (choose one):
☐ Never smoked ☐ Quit smoking ☐ Less than pack/day ☐ Up to 2 packs/day ☐ More than 2 packs/day
If you smoke or used to smoke, How long? _________ yrs. If you quit smoking, when? (date)__________

Do you use alcohol? (choose one):
☐ Never ☐ Quit drinking ☐ Less than 3 drinks/week ☐ Up to 14 drinks/week ☐ More than 14 drinks/week

Form MMHWC enrollment 20070213.1

MUNSON MEDICAL CENTER
Healthy Weight Center

Enrollment Form Patient Initials: ____________

Has any member of your immediate family (parents, brothers, sisters) ever had: (choose all that apply):

☐ Cardiovascular disease	☐ Breast Cancer	☐ None
☐ Diabetes (type 1 or type 2)	☐ Colon Cancer	
☐ Gout	☐ Lung Cancer	
☐ High Blood Pressure	☐ Ovarian Cancer	
☐ Obesity	☐ Prostate Cancer	
☐ Osteoarthritis	☐ Other Cancer	
☐ Sleep Apnea	☐ Alcoholism	
☐ Stroke	☐ Other (list): ____________________________	

Indicate what types of medication you are currently taking (prescription and over the counter - choose all that apply):

☐ NONE	☐ for Depression	☐ None
☐ for Weight Loss	☐ for Anxiety	
☐ for High Blood Pressure	☐ for Sleep	
☐ for Heart Disease	☐ for Hypothyroidism	
☐ for Birth Control	☐ for Gout	
☐ for Hormone Replacement	☐ for Allergies	
☐ for Diabetes	☐ OTHER	

List ALL medication you are currently taking in the box below (prescription and over the counter, including vitamins – include the name of the medication, dosage, and frequency for each medicine): ☐ I am not taking any prescription medications

List any medication allergies: ____ ☐ None

List any food allergies: ____ ☐ None

List any hospitalizations for surgery, major illness or injury that required an overnight stay (include date):

____ ☐None

____

Form MMHWC enrollment 20070213.1

MUNSON MEDICAL CENTER
Healthy Weight Center

Enrollment Form   Patient Initials: _____________

Indicate what symptoms you are currently experiencing (choose all that apply):

☐ Vision problems	☐ Vaginal bleeding
☐ Hearing problems	☐ Unusual skin lumps
☐ Swallowing problems	☐ Breast lumps or changes
☐ Shortness of breath	☐ Pain in hands
☐ Chest pain	☐ Pain in feet
☐ Palpitations	☐ Pain in hips
☐ Wheezing	☐ Pain in knees
☐ Indigestion/Nausea	☐ Pain in back
☐ Lactose intolerance	☐ Pain in neck
☐ Abdominal pain	☐ Pain in shoulder
☐ Diarrhea	☐ Pain in elbow
☐ Constipation	☐ Skin rash
☐ Vomiting	☐ Numbness/Tingling
☐ Rectal Bleeding	☐ Trouble walking
☐ None	☐ Other (list)________________

Do you have a history of: (choose all that apply)

Anorexia	☐ Never	☐ Past	☐ Present
Bulemia	☐ Never	☐ Past	☐ Present
Binge eating	☐ Never	☐ Past	☐ Present
Incest/sexual abuse	☐ Never	☐ Past	☐ Present

Once you have completed page two through page five of this enrollment form, be sure to add your initials to the top left corner of all four pages. Page six and seven will be completed by a staff member at the conclusion of your Orientation meeting.

Important Note – You must hand in your registration and enrollment forms, as well as your physician's authorization before your program start appointment will be scheduled. If you have any questions, please contact one of the Munson Medical Healthy Weight Center staff members.

Hint *– To use betterMD.net, please disable any pop-up blockers and change your email/spam filter settings to accept important email from betterMD.net and MMHWC staff messages. Contact us if you need help with this.*

In accordance with the NOTICE OF PRIVACY PRACTICES that you previously read and signed at Munson Medical Healthy Weight Center (MMHWC), this notice informs you that the MMHWC will share the information contained in this document and other information gathered during your participation in the Weight Management Program with the company betterMD.net, Inc. By signing below you are indicating that you previously read the above stated notice and are fully aware of, and will allow, the sharing of your weight management related information with betterMD.net, Inc.

Signature: ___________________________________ Date: _____________

Form MMHWC enrollment 20070213.1

MUNSON MEDICAL CENTER
Healthy Weight Center

Enrollment Form Patient Initials: _____________

STAFF USE ONLY

Physical Exam Worksheet

Patient Name of Record: ____

EMR Identification Number: ____

Height: _________ inches Weight: __________ lbs. Waist Circumference: __________ inches

Hip Circumference: __________ inches BP: ________/________ Heart Rate: __________ bpm.

Lab values: ☐ Labs recorded below (drawn on: ____/____/____) ☐ Labs requested ☐ Labs not required

Tot Cholesterol: _________ LDL: _________ HDL: _________ Triglycerides: _________

Hgb A1c: _________ Fasting Glucose: _________ Thyroid (TSH) : _________

For which Healthy Weight Center program is this patient enrolling? (please check one):
☐ Working Off Weight (W.O.W.) – 4 month program
☐ Comprehensive Weight Management – 6 month program

Visit setting: ☐ Individual session ☐ Group session

These GOAL Weight entries require body mass measurements - DO NOT record weight LOSS goals

Initial weight goal: I want to weigh ______ lbs. in 4 weeks
Long-term weight goal: I want to weigh ______ lbs. eventually

Motivations to lose weight (choose two)
☐ improve health ☐ improve appearance ☐ feel better ☐ live longer
☐ wishes of family members ☐ wishes of friends or others
OTHER (not listed): ____

Barriers to success (choose two)
☐ exercise ☐ lack of motivation ☐ poor food preparation ☐ poor food choices
☐ inability to control eating/portion sizes ☐ lack of time ☐ money
☐ lack of support from family or others

OTHER (not listed): ____

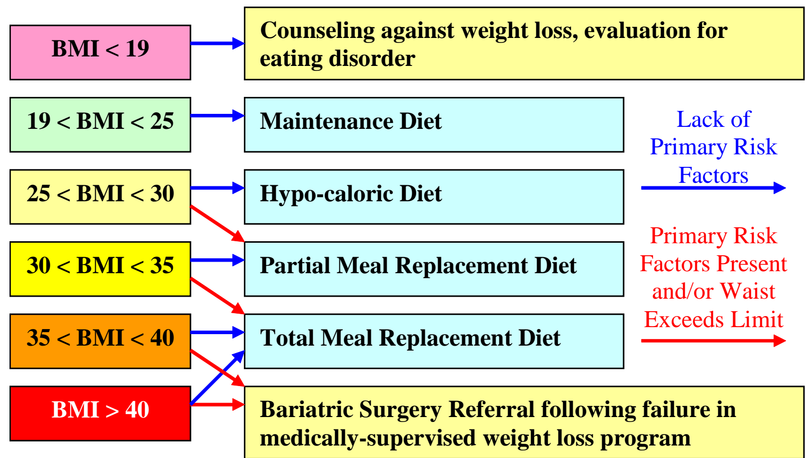
Form MMHWC enrollment 20070213.1

MUNSON MEDICAL CENTER
Healthy Weight Center

Enrollment Form

Patient Initials: ____________

Treatment Plan Protocol



Treatment Plan (choose one):

☐ **Total Meal Replacement** (full supplements – estimated rate of loss 3-5 lbs/wk)
☐ **Partial Meal Replacement** (partial supplements with food plan – estimated rate of loss 2-3 lbs/wk)
☐ **Hypo-caloric** (no supplements with 700 cal deficit whole food plan – estimated rate of loss 1-2 lbs/wk)

If the Treatment plan is not selected according to this protocol, please indicate the reason for your choice:

☐ PCP Preference ☐ Patient Preference ☐ Comorbidity ☐ Financial Considerations ☐ Supplement Intolerance
☐ Other: ____

Physician consent received? ☐ Yes ☐ No ☐ n/a (non-supplemented plan)

Has a start date appointment been scheduled? ☐ Yes ☐ No Date of the appointment: ____/____/______

Other comments:

Staff member (signature): ____

Staff member (please print): ______________________________ Date of service: ______/______/______

Form MMHWC enrollment 20070213.1

MUNSON MEDICAL CENTER
Comprehensive Weight Management Program

Meal Plan Options

All diet plans are supported by medical research as effective means for losing weight.

Meal Plan: *Hypocaloric*

This plan has been designed to provide optimum nutrition that will help you lose or control your weight and maintain health. Along with regular exercise and lifestyle education, this plan is designed to help you lose 1-2 pounds per week, although results may vary from person to person. This plan includes the use of whole foods that are portion based on food groups and calorie content, but can also include the use of meal replacement supplements. The calorie range for this plan is 1,200 to 1,600 calories per day. Eating from a wide variety of foods provides better overall nutrition.

Meal Plan: *Partial Meal Replacement*

This plan uses a structured diet of pre-packaged entrees (purchased at the grocery store), diary products, fruits and vegetables, plus approximately 4 packets of meal replacement supplements (purchased from our vendor) per day. This plan along with regular exercise and lifestyle education is designed to help you lose 2-3 pounds per week. The calorie range for this is 1,000-1,200 calories per day. This plan may be recommended for those who are 25 to 50 pounds overweight.

There is an additional cost of approximately $41-62 per week for supplements.

Meal Plan: *Total Meal Replacement*

This plan exclusively uses protein based meal replacement supplements. The typical plan equals 600-800 calories per day. For safe progress, patients on this plan may be required to make and attend follow-up visits at the Healthy Weight Center Clinic with our program Medical Director, or with your own Primary Care Provider. These appointments are not included in the program fee. This plan along with regular exercise and lifestyle education is designed to help you lose 3-5 pounds per week, and is best for those who are 25 – 100+ pounds overweight.

There is an additional cost of approximately $65-88 per week for supplements.

MUNSON MEDICAL CENTER
Comprehensive Weight Management Program

Scheduling Guide

Intake Assessment ***Location: Munson Community Health Center, 550 Munson Avenue***

A 90-minute appointment to determine if you are ready for the program.

First Visit

Each part of your "First Visit" is 50 to 60 minutes in duration.

- Registered Dietitian: ***Location: Munson Community Health Center, 550 Munson Avenue***
- Social Worker ***Location: Munson Community Health Center, 550 Munson Avenue***
- Exercise Specialist ***Location: Munson Community Health Center, 550 Munson Avenue***

Registered Dietician ***Location: Munson Community Health Center, 550 Munson Avenue***

Depending on need, schedule ten to sixteen to half-hour sessions based on your Registered Dietitian's recommendations. You must attend a minimum of 10 sessions for successful completion of this portion.

Behavioral Health ***Location: Munson Community Health Center, 550 Munson Avenue***

At your first appointment, the behavioral health specialist will determine how many sessions are necessary. Five to eight sessions are available to you throughout your time in the program. You must attend a minimum of 5 sessions for successful completion of this portion.

Exercise Specialist ***Location: Munson Community Health Center, 550 Munson Avenue***

Seven (7) individual sessions required. Your first session will be one hour in duration; the remaining six will be a half-hour in duration. You must plan for a half-hour of cardio (on your own) **before** your individual sessions with the exercise specialist. You must attend a minimum of 6 sessions for successful completion of this portion.

Supervised Exercise ***Location: Munson Community Health Center, 550 Munson Avenue***

One session required each week throughout the duration of the program (unless you choose to participate in the circuit training class). An exercise specialist will be available to assist you throughout your workout and will obtain your weight at the beginning of each session. You must attend a minimum of 10 sessions for successful completion of this portion.

Group Education ***Location: Munson Community Health Center, 550 Munson Avenue***

Schedule a total of eight classes in the last eight weeks of the program (Class is held on Thursdays at 5:30 p.m. in Conference Room E) Speakers for the classes will rotate between the Behavioral Health Specialist and the Registered Dietitian. See class schedule for topics. You must attend a minimum of 6 classes for successful completion of this portion.

Circuit Training ***Location: Munson Community Health Center, 550 Munson Avenue***

This class follows the Group Education class on Thursday evenings. Circuit training begins at 6:30 p.m. and is located in the Physical Therapy Gym. You must attend a minimum of 6 sessions for successful completion of this portion.

We do have a 24-hour cancellation policy. If you need to make any changes in your schedule, please do so at least 24 hours in advance by calling ***(231) 935-8533.*** *Cancellations with less than 24 hours advanced notice or no-shows cannot be made up. A total of 3 missed appointments may lead to dismissal from the program.*

MUNSON MEDICAL CENTER

Healthy Weight Center

Staff Hours of Operation

Monday			
Behavioral Health (Julie)	8:00 am	-	1 pm *(closed at 1)*
Dietician (Connie)	8:30 am	-	12 pm *(closed at 12)*
Supervised Exercise (Sarah)	11:15 am	-	12:30 pm *(unavailable after 10/1/2009)*
Individual Exercise (Sarah)	3:00 pm	-	7:00 pm *(closed at 7)(available 12/2009)*

Tuesday			
Individual Exercise (Sarah)	3 pm	-	7pm *(closed at 7)*
Dietician (Patti)	3:30 pm	-	6:30 pm *(closed at 6:30pm)*

Wednesday			
Individual Exercise (Sarah)	8 am	-	12:30pm (*closed at 12:30)*
Supervised Exercise (Ron)	3:15 pm	-	4:30 pm
	4:45 pm	-	6:00 pm
	6:15 pm	-	7:30 pm
Behavioral Health (Vince)	8 am	-	10 am *(closed at 10)*
Dietician (Connie)	4:30 pm	-	6:30 pm *(closed at 6:30)*

Thursday			
Individual Exercise (Sarah)	7:30 am	-	11 am *(closed at 11)*
Individual Exercise (Ron)	7am	-	11am *(closed for lunch)*
	12pm	-	2pm *(closed at 2pm)*
Behavioral Health (Julie)	2:30 pm	-	4:30 pm *(every other week)*
	2:30 pm	-	6:30 pm *(every other week)*
Dieticians			
Patti/Connie(1st & 2nd Th)	2:30 pm	-	5 pm *(closed at 5)*
Patti/Connie(3rd, 4th & 5th Th)	2 pm	-	5 pm *(closed at 5)*
Connie (every other week)	4:30 pm	-	7:30 pm *(closed at 7:30)*
Patti (every other week)	4:30 pm	-	5 pm *(Group Ed 5:30-6:30)*
	7 pm	-	7:30 pm *(closed at 7:30)*

Friday			
Supervised Exercise (Ron)	7:00 am	-	8:15 am
	8:30 am	-	9:45 am
	10 am	-	11:15 pm
Individual Exercise (Sarah)	7:30 am	-	9 am *(unavailable after 12/2009)*
Dietician (Patti)	8:00 am	-	11:30 am *(closed for lunch)*
	12:30 pm	-	2 pm *(closed at 2)*

Follow-up dietician appointments are 30 minutes, exercise 30 minutes and behavioral health 50 minutes. All supervised exercise appointments are 1 hour and 15 minutes.

*** All clinicians are available on pagers for emergencies only.**

Patti Hennrick,(231) 318-8607
Connie Metcalf, (231) 318-8608
Ron Hessem, (231) 318-9369
Julie Clynes, (231) 318-9183
Sarah Wetmore, (231) 318-1229