MUNSON HEALTHCARE

Healthy Weight Center Referral Form

Fax form to: **Healthy Weight Center**
FAX: (231) 935-8609 **PHONE: (231) 935-8606**

Insurance: _____ Member ID #:_____

Patient Name:_____ D.O.B.: _____/_____/_____
(Last) (First)

Address: _____
(Street) (City) (Zip)

Phone: Home (_____)_____ Other: (_____)_____

****<u>If insurance is Priority Health:</u> HAS MEMBER AGREED TO COMPLY WITH A MEDICAL WEIGHT MANAGEMENT PROGRAM THAT INCLUDES AT LEAST 6 OFFICE VISITS WITH PRIMARY CARE PROVIDER OVER 6 MONTHS?**

◯Yes___/___/___ ◯No

CLINICAL CONDITION

Date measured: _____ Current Weight: _____ Current Height: _____ BMI: _____

CO-MORBIDITIES: CHECK ALL THAT APPLY AND LIST MEDICATIONS FOR EACH AS APPLICABLE

◯ **Diabetes** *(HbA1C greater than 8.0)* **HbA1C** _____ **Medications**:_____

◯ **Hypertension** (*requiring medication)* **Medications**:_____

◯ **GERD** *(persistent symptoms despite daily medications)* **Medications**:_____

◯ **Symptomatic Sleep Apnea** **A/H Index =** _____

◯ **Significant cardiac disease** *(Documented ASHD, LVH or RVH)* **Diagnosis**:_____

◯ **Hyperlipidemia** *(greater than 30mg/dl above goal) requiring medication (list all medications below)*

HDL: _____**LDL:** _____**TG:** _____**Total:** _____ **Medications**:_____

◯ **Degenerative joint disease** *markedly limiting daily activities*

◯ **Non-alcoholic steatohepatitis (NASH)**

◯ **Depression** *requiring medication* ***<u>and</u>*** *psychological counseling* **Medications**: _____

◯ **No co-morbidities present**

CONTRAINDICATIONS TO PHYSICAL ACTIVITY

◯ Unrestricted

◯ Limitations:_____

1. **WILL YOU ALLOW YOUR PATIENT TO BE PLACED ON A TOTAL MEAL REPLACEMENT PLAN AS BRIEFLY DESCRIBED BELOW?** **◯ Yes** **◯No**

<u>TOTAL MEAL REPLACEMENT PLAN:</u> ●600-800 calories/day ●70 grams of Protein/day

●Recommended for > 25 lb. loss ●Use of nutritionally complete meal replacements (~ $65-88/week)

2. **WOULD YOU LIKE OUR MEDICAL DIRECTOR TO SEE YOUR PATIENT FOR ROUTINE FOLLOW UP VISITS REGARDING THEIR WEIGHT LOSS PROCESS?** (please indicate your approval by checking the appropriate box)

◯ Yes **◯ No**

Primary Care Provider: _____ **Signature:**_____

PCP Phone: (231)_____ **PCP Fax: (231)**_____