MUNSON HEALTHCARE

Healthy Weight Center Referral Form

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

Insurance: _____ Member ID #:_____

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

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

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

☑ **Dietary Counseling and Surveillance** **Code: Z71.3**

CO-MORBIDITIES: Please list or check all that apply below:

☐No co-morbidities present

☐Overweight Code:_____

☐Obesity Code:_____

☐Diabetes Medications:_____ Code:_____

☐Hypertension Medications:_____ Code:_____

☐Hyperlipidemia Medications:_____ Code:_____

Diagnosis:_____ Code:_____

Diagnosis:_____ Code:_____

Diagnosis:_____ Code:_____

Diagnosis:_____ Code:_____

Date measured: _____ Wt: _____ Ht: _____ BMI: _____ Code:_____

Lab Data (If not on Powerchart):

Date:_____ Chol:_____ TG:_____ HbA1C:_____

HDL:_____ LDL:_____

CONTRAINDICATIONS TO PHYSICAL ACTIVITY

☐Unrestricted

☐Limitations:_____

I ALLOW MY PATIENT TO BE PLACED ON A TOTAL MEAL REPLACEMENT PLAN AS BRIEFLY DESCRIBED BELOW?
TOTAL MEAL REPLACEMENT PLAN:

●800-900 calories/day ●95grams/protein ☐ **Yes** ☐ **No**

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

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

Updated 2/25/2016