Patient Referral Form

Patient Information

Name____________________ Sex________ Social Security# ____________________

Height____________ Weight__________ BMI__________ Date of Birth____________________

Address____________________ City______________ State________ ZIP________

Patient Phone (primary):____ ____________________Alternate Phone: ____________________

Insurance

Provider ____________________Policy Holder Name ____________________

Policy Holder Date of Birth____________________ Relationship to Patient____________________

Employer____________________ Insurance ID#____________________

Group #____________________ Referral Authorization # (if required) ____________________

Medical History/Comorbidities (please check all that apply)

☐ Acid Reflux

☐ Degenerative Joint Disease

☐ Asthma

☐ Congestive Heart Failure/Class______

☐ Coronary Artery Disease

☐ Diabetes

☐ Heart Attack

☐ High Cholesterol

☐ Hypertension

☐ Sleep Apnea

☐ Stomach/Bowel Problems

☐ Stroke

☐ Transient Ischemic Attack (TIA)

☐ Other (please describe any other relevant conditions: ____________________

Medications: ____________________

Previous Weight Loss Attempts____________________

☐ I have attached laboratory results/patient's medical records for your review.

Referring Physician Information

Name: ____________________Phone:____________________Fax:____________________

Email: ____________________

When complete, please fax to: New Patient Coordinator 503-227-2462