2018 Clinch Avenue
Knoxville, Tennessee 37916

Healthy Ways Clinic Referral Form

Dear Provider:

Thank you for your interest in the Healthy Ways Clinic (formerly known as Pediatric Weight Management Clinic). Our Patient Referral Form is the first step to enroll your patient in a treatment program that could help them experience long-lasting lifestyle changes.

Please complete **all information on the form** and provide us with a copy of front and back of the patient's insurance cars. We also ask that you include a copy of the growth chart for your patient and recent office notes. When completed and signed, please mail or fax it to the clinic.

We will then contact the family and let you know when the patient has been scheduled.

Healthy Ways Clinic
2018 Clinch Avenue
Knoxville, Tennessee 37916
Fax: 865-541-8405

Patient Information

1. Primary Care Information

Name of primary provider:____________________

Office/clinic address: ____________________

City:____________________ State: ________ ZIP Code:__________

Office/clinic phone:____________________ Office fax: ____________________

Physician' e-mail:

2. Patient Information

Patients name: ____________________

Date of birth:________________ Male____ Female:_____ Social security #: ________________

Street address: ____________________

City:____________________ State: ________ ZIP Code:__________

Home phone (include area code) ________________ Primary language of patient ________________

Parent/guardian (First and last name) ____________________

Phone number (if different from above)________________ Primary language of parent: ________________

3. Reason for appointment *****THIS SECTION MUST BE COMPLETED*****

Weight: ________ Height:________ Body mass index(kg/m2)__________ Date measured:____________

Current medications: ____________________

Abnormal Labs: Date Drawn: ________________ Fasting ☐ Yes ☐ No

Presenting problems:

☐ Acanthosis nigricans ☐ Hypertension ☐ GI ☐ Sleep apnea ☐ Cholesterol/triglycerides
☐ Asthma ☐ Diabetes ☐ Insulin resistance ☐ Depression ☐ Venous stasis disease
☐ Joint/Back pain ☐ irregular or absent menses ☐ Urinary incontinence
☐ Impaired activities of daily living
☐ Other: ____________________

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Please briefly describe other methods the patient has previously used to lose weight: ________________

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____________________ ____________________

Signature of primary provider Date

Form No. 32000 (8/19)