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 cards. 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.
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: ___________________________________________________________________________________
__________________________________________________________________________________________

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

_____________________________________________  __________________________
Signature of primary provider  Date