

WEIGHT & WELLNESS

PHYSICIAN REFERRAL FORM

FAX TO: Omaha 402-955-4078 OR Lincoln 402-955-8799

Patient Name: _____ Date of Birth: ____/____/____

Parent(s)' Names: _____

Parent(s)' Address: _____

Phone Number: _____ Male Female

Preferred Language _____ Does the family need an interpreter? Yes No

Physician Completing Form: _____ Physician group _____

Physician Phone Number: _____ Fax Number: _____

REQUIRED PATIENT INFORMATION: *(Necessary in order to accept this referral)*

Recent Height: _____ cms Recent Weight: _____ kgs. BMI: _____

BMI must be greater than 95% or greater than 85% with a co morbidity in order to qualify for this clinic.

Lab results/diagnostic testing Please include when faxing the referral form:

• Any labs or test results within the last 6 months

HGB AIC Chem 14 Fasting Lipid Panel TSH Other

Most recent H & P and last clinic note Immunization Record Growth Chart

Diagnosis: _____ ICD-10: _____

Reason for Referral: Obesity Weight Loss Management Bariatric Surgery

Additional information: _____

Type of Service Requested

Consult and recommend management Consult and treat Bariatric Surgery Evaluation

Follow-up Other Is family aware of consult for the Weight & Wellness Clinic? YES NO

Insurance Information *Please include a copy of the insurance card if available*

Plan Name: _____ ID # _____

Group # _____ Plan Address: _____

Plan Phone Number: () _____ Plan Fax Number: () _____

Contact information

Weight & Wellness, Attn: Nurse Case Manager, Omaha office Fax: 402-955-4078 • Phone: 402-955-4080

Lincoln office Fax: 402.955.8799 • Phone: 402.486-1513

Please Sign

I certify that I have examined this child and reviewed all test results. I believe that this patient is appropriate for admission into the Children's Hospital & Medical Center Weight & Wellness specialty clinic and does not require hospitalization at this time.

Physician Signature _____

Date _____