Pediatric Weight Management Clinic

Patient Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian: _____ Relationship: _____

Preferred Language: _____ Interpreter Needed: Yes / No

Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Alternate Phone: _____

Referral Source Information

Referring Provider: _____

BMI: _____ BMI Percentile: _____ Height: _____ Weight: _____

Any specific areas of concern?

- ☐ Rapid weight gain
- ☐ Family history
- ☐ Psychological (depression, disordered eating, anxiety, etc.)
- ☐ Elevated lipids
- ☐ Elevated liver enzymes
- ☐ Type 2 diabetes
- ☐ Other: _____

Is this patient interested in bariatric surgery? Yes / No / Never discussed

Please fax demographic information and any of the following lab work if available with your referral form.

- ☐ Chem 14
- ☐ TSH
- ☐ Fasting lipid panel
- ☐ Hgb A1C
- ☐ Fasting insulin level

Fax Number: 531-355-0028

Please call 531-355-6464 with any questions regarding your referral.

Referral Process

Our schedulers make three attempts to contact the family. If we are unable to reach them, or they are not interested in the program, we will send you notification.

We greatly appreciate your referral!