

A Better Way

HEALTH

Center



An Affordable Program to Achieve and Maintain a Healthy Weight Without Hunger

Patient Referral Form

To: A Better Way Health Center Medical Staff

From:

_____, (Physician Name)

_____, (Clinic)

_____, (Street)

_____, (City, State, Zip)

_____, (Phone, Email address)

_____, (Patient Name)

a patient under my care as his/her _____, (e.g., Primary Care Provider, Internist, Cardiologist, Obstetrician-Gynecologist) is being referred by me to A Better Way Health Center's Weight Management Program for evaluation and treatment. I have discussed with this patient the health implications of his/her current overweight condition, and we both concur that behavioral attempts to improve this condition have produced less than satisfactory results to date. I understand that A Better Way Health Center's medical staff will evaluate this patient for program eligibility, with referral back to his/her primary care provider should either a previously undisclosed medical condition be detected or further workup be deemed prudent. I also understand that A Better Way Health Center's program emphasizes long-term weight management, incorporating instruction in proper nutrition and appropriate exercise, behavioral guidance, and at the discretion of both the Center's medical staff and the patient, the use of the appetite suppressant, phentermine, if not medically contraindicated.

Checked below are the weight-related risk factors or medical conditions which apply to this patient. If the patient's Body Mass Index (BMI) is under 27.0 kg/m2, I have elaborated on the patient's risk(s) or condition(s) which could benefit from even modest weight loss. A separate page is attached, if necessary.

BMI = (Weight (lbs) / (Height (inches))²) * 704.5 >=30___ 27.0-29.9___ 25.0-26.9___ <25.0___

Risk Factors (Family History/Laboratory)

Medical Conditions

___ Type 2 Diabetes

___ Hypercholesterolemia

___ Type 2 Diabetes

___ Sleep Apnea

___ CHD

___ Elevated LDL/HDL ratio

___ CHD

___ Osteoarthritis

___ Stroke

___ Decreased Glucose Tolerance

___ Angina (stable)

___ Gallstones

___ Breast CA

___ Waist Circumference

___ Peripheral

___ Hypertension

___ Colon CA

(Men >40"; Women >35")

Vascular Disease

(medication-controlled)

___ Endometrial or Prostate CA

___ Other _____

Dietary Considerations (e.g., food allergies, special nutritional requirements) _____

Physical Activity Restrictions _____

Special Considerations _____

_____, (Signature)

Southdale Medical Center

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www.abetterwayhealthcenter.com