**PHYSICIAN REFERRAL FORM FAX this form to: 402-955-4078**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Parent(s)’ Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent(s)’Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email 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 W&W 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 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 Clinic and does not require hospitalization at this time.

Physician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E.R.O.E.S. Weight Related Illness Clinic