Weight & Wellness Specialty Care

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 _____