

Healthy You Weight Management Program Physician Prescription Form

PATIENT'S NAME _____

Parent/Guardian name _____

Phone # _____ Cell _____ Work _____

Mailing Address _____

Age _____ DOB _____ Weight _____ Height _____ BMI% _____ Male / Female _____ Race _____

How much weight has this patient gained over the past year? _____

DIAGNOSIS (please check all that apply)

<input type="checkbox"/>	Abnormal Weight Gain	783.1	<input type="checkbox"/>	Acanthosis Nigricans	701.2	<input type="checkbox"/>	Depressive D.O. NOS	311
<input type="checkbox"/>	BMI >85 - <95	V85.53	<input type="checkbox"/>	Hypertriglyceridemia	272.1	<input type="checkbox"/>	Anxiety D.O. NOS	300.0
<input type="checkbox"/>	BMI >95	V85.54	<input type="checkbox"/>	Impaired Glucose Tolerance Test	790.22	<input type="checkbox"/>	ADHD NOS	314.9
<input type="checkbox"/>	Dysmetabolic Syndrome	277.7	<input type="checkbox"/>	Obstructive Sleep Apnea	327.23			
<input type="checkbox"/>	Hypercholesterolemia	272.0	<input type="checkbox"/>	Sleep Apnea	780.57	<input type="checkbox"/>	Hypertension	401.9
<input type="checkbox"/>	Hyperlipidemia	272.2	<input type="checkbox"/>	Sleep Disturbance	780.5	<input type="checkbox"/>	Elevated Blood Pressure	796.2
<input type="checkbox"/>	Hypertriglyceridemia	272.1	<input type="checkbox"/>	Snoring	786.09			
<input type="checkbox"/>	Essential Hypertension	401.0	<input type="checkbox"/>	Asthma	493.00 493.92	<input type="checkbox"/>	Hip Joint Pain	719.45
						<input type="checkbox"/>	Pes Planus (Flat Foot)	734
<input type="checkbox"/>	Gastroesophageal Reflux	530.81	<input type="checkbox"/>	Urinary Incontinence	788.39	<input type="checkbox"/>	Knee Joint Pain	719.46
<input type="checkbox"/>	Elevated LFTs	790.6	<input type="checkbox"/>	Amenorrhea	626	<input type="checkbox"/>	Ankle/Foot Joint Pain	719.47
<input type="checkbox"/>	Steatohepatitis	571.8	<input type="checkbox"/>	Oligomenorrhea	526.1	<input type="checkbox"/>	Low Back Pain	724.2
			<input type="checkbox"/>	Gynecomastia	611.1	<input type="checkbox"/>	Exercise Intolerance	V69.9

Other _____

LABS DONE WITHIN 6 MONTHS - YES or NO @ CHKD, @ SENTARA, or OTHER _____

Primary Insurance Company _____

Name of Policy Holder _____ DOB _____

Subscriber # _____ Group # _____

Relationship to Subscriber _____

Secondary Insurance Company _____

Name of Policy Holder _____ DOB _____

Subscriber # _____ Group # _____

Relationship to Subscriber _____

If insurance referral is required by patient's insurance provider, REFERRING physician is responsible for obtaining the referral from insurance company. AUTHORIZATION # _____

The patient will be evaluated by the Healthy You for Life team including:

- The Healthy You Physician • Registered Dietitian • Physical Therapist • Licensed Clinical Social Worker

Date _____

Physician's signature / Date **I certify that the services listed above are all medically necessary.**

/

Physician's phone number and name PRINTED Name of Physician Practice

This form may be **FAXED to 668-7809** or mailed with the program registration form.

If you have questions, please contact Babs Benson, RN at 668-7035.