NorthStar
MEDICAL AND SURGICAL
WEIGHT MANAGEMENT

Please fax to: (360) 676-6636

Patient Name:_____Phone: _____

Primary Insurance:_____Referral Date: _____

Medical Weight Management

- ❑ Evaluate & Treat:
  - Initial Evaluation to include: History, Physical Exam, Laboratory Testing, EKG and Body Composition Testing
- ❑ Pre-Surgical Weight Reduction
- ❑ Post-Surgical Management

- Nutrition Plan for Weight Maintenance
- Appetite Control (if indicated)
- Behavioral Modification
- Exercise Prescription

Indication for Referral

- ❑ Diabetes
- ❑ Insulin Resistance
- ❑ CAD / Dyslipidemia
- ❑ Obesity
- ❑ Musculoskeletal Issues
- ❑ Hypertension
- ❑ Depression
- ❑ Eating Disorder

PLEASE INCLUDE:

- Patient fact sheet or demographics
- Any copies of relevant office notes, history and physical

Thank you for your kind referral

Provider's Signature: _____

Provider's Name:_____**c.c. Report To:** _____

Telephone: (_____)_____ **Fax:** (_____)_____

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