Goshen Physicians
CENTER FOR WEIGHT REDUCTION

Fax – New Patient Referral Form

Attention:

From:

Fax number: 574-537-1034

Today's Date:

Total pages, including cover:

Phone number:

Please complete this form and fax. Goshen Physicians Center for Weight Reduction will contact the patient to schedule an initial consultative appointment. This ensures patient understanding and commitment to the lifestyle changes needed to be successful in the Goshen Physicians Center For Weight Reduction programs. Please fill out completely for your patient to receive the best service.

PATIENT INFORMATION:

Patient Name: _____ DOB:_____

Address: _____ Email:_____

City: _____ State:____ Zip:_____

Home #: _____ Cell #: _____

Primary Insurance: _____ Secondary Insurance: _____

ID#: _____ Group #: _____ Provider Services Phone #:_____

Reason for Referral:_____

PATIENT HEALTH HISTORY:

Height: _____ Weight: _____ BMI: _____

Medical History/Co-morbidities (please check all that apply):

☐Acid Reflux (GERD) ☐Arthritis ☐ Diabetes – Type 1 ☐Diabetes – Type 2 ☐High Cholesterol ☐Hypertension

☐Obstructive Sleep Apnea

Other (please describe any other medically relevant conditions): _____

_____

PROVIDER INFORMATION:

Referring provider: _____ Form completed by: _____

Referring provider fax #: _____