



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 #: _____