

Sparrow Weight Management Center

517.364.8080 (phone)

517.364.8088 (fax)

Referral Form

Date: _____

Referring Physician: _____

Telephone Number:() _____ Fax:() _____

Office Contact Person: _____

Patient Name: _____ Date of Birth: _____

If patient is under 18, parent/guardian name: _____

Address: _____

Patient's telephone number: () _____

Insurance: _____ Policy #: _____

Height: _____ Weight: _____

Co-morbidities:

Hypertension

Diabetes

Hyperlipidemia

Degenerative Joint Disease

Sleep Apnea

Heart Disease

Other: _____

Medications: _____

Program of Choice:

Weight Management (Optifast)

Children/Adolescent

Gastric Bypass (Roux-en-Y)*

Lap Band*

Other: _____

*If Bariatric Surgery, please include information on previous weight loss attempts with in the past five (5) years, especially medically supervised programs.

Thank you for your referral.