Provider Supervised Weight Loss Visit

This form must be completed at each PCP visit as required by insurance

Completed forms should be scanned into the EMR and FAXED to 833-715-6611

Date: ____________________

Provider Completing Form: __________________________________

Patient Information:

Name: ____________________________________ DOB:_____________________

WT: ____________ HT: ___________ BP: ____________ Pulse: __________ TEMP: ___________

Diagnosis:

1) Obesity (E66.01) 2) __________________ 3) __________________ 4) ___________________

5) __________________ 6) ___________________ 7) ___________________

Current Dietary Program:

☐ Low Fat ☐ Weight Watchers ☐ Atkins ☐ South Beach ☐ Thrive ☐ Diabetic Diet

☐ Dietitian ☐ Other: please list ____

____

Physical Activity/Exercise Program:

☐ Increased daily physical activity ☐ Target HR 3x/week ☐ Walking ☐ Gym Attendance
☐ Other: please list

____

Behavioral Interventions:

☐ Meeting with dietitian ☐ Food journaling ☐ Support group ☐ www.fitday.com

☐ Other

____

Consideration or use of Pharmacotherapy with FDA approved medication:

☐ Pharmacotherapy contraindicated secondary to medical condition

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☐ Patient agrees to follow-up every 3 months for the 1st year following bariatric surgery

Addition Comments and/or recommendations:

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Provider Signature: _______________________________________

2023.05.22 SH

Form Number _________

AdventHealth
Redmond