



2018 Clinch Avenue  
Knoxville, Tennessee 37916

## Healthy Ways Clinic Referral Form

Dear Provider:

Thank you for your interest in the Healthy Ways Clinic. Our clinic serves children who are overweight or obese. Your patient must have a body mass index (BMI) above the 85th percentile for gender and age in order to participate. Our Patient Referral Form is the first step to enroll your patient in a treatment program that could help them experience long-lasting lifestyle changes.

Please complete **all information on the form** and provide us with a copy of front and back of the patient's insurance cards. We also ask that you include a copy of the growth chart for your patient and recent office notes. When completed and signed, please mail or fax it to the clinic.

We will then contact the family and let you know when the patient has been scheduled.



Healthy Ways Clinic  
2018 Clinch Avenue  
Knoxville, Tennessee 37916  
Phone: (865) 541-8830  
Fax: (865) 246-7568

# Healthy Ways Clinic Referral Form

## 1. Patient Information

Patients name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Male \_\_\_ Female: \_\_\_ Social security #: \_\_\_\_\_  
Street address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
Home phone (include area code) \_\_\_\_\_ Primary language of patient \_\_\_\_\_  
Parent/guardian (First and last name) \_\_\_\_\_  
Phone number (if different from above) \_\_\_\_\_ Primary language of parent: \_\_\_\_\_

## 2. Primary Care Information

Name of primary provider: \_\_\_\_\_  
Office/clinic address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
Office/clinic phone: \_\_\_\_\_ Office fax: \_\_\_\_\_  
Physician' e-mail: \_\_\_\_\_

## 3. Reason for appointment **\*\*\*THIS SECTION MUST BE COMPLETED\*\*\***

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Body mass index(kg/m2) \_\_\_\_\_ Date measured: \_\_\_\_\_  
BMI for age percentile \_\_\_\_\_ BMI >85th? \_\_\_\_\_ Patient is \_\_\_\_\_ Overweight \_\_\_\_\_ Obese  
Current medications: \_\_\_\_\_  
Abnormal Labs: Date Drawn: \_\_\_\_\_ Fasting  Yes  No

### Presenting problems:

- Acanthosis nigricans  Hypertension  GI  Sleep apnea  Cholesterol/triglycerides
- Asthma  Diabetes  Insulin resistance  Depression  Venous stasis disease
- Joint/Back pain  Irregular or absent menses  Urinary incontinence
- Impaired activities of daily living
- Other: \_\_\_\_\_

Please briefly describe other methods the patient has previously used to lose weight: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Service requested:

- Evaluation and treatment by Physician, Psychologist, Registered Dietician, Physical Therapist

\_\_\_\_\_  
Signature of referring provider

\_\_\_\_\_  
Date