UCLA Health System

MRN:
Patient Name:

(Patient Label)

UCLA Fit for Healthy Weight Program
REFERRAL FORM

Fax: 310-301-5391- Phone: 310-825-6469 - www.fitprogram.ucla.edu
UCLA FIT FOR HEALTHY WEIGHT PROGRAM; Room A2-125 CHS, Los Angeles, CA 90095

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Date of Referral: _____ UCLA ID# (if known): _____

Height (cm/ in): _____ Weight (lbs /kg): _____ BMI: _____ BMI %ile: _____ (Must be > 85%ile)

Readiness for Change (Scale 1 to 10 – Not Ready to Very Ready): Child _____ Mother _____ Father _____

Street Address: _____ Home #: _____

Referring MD: _____ Specialty: _____ Email: _____

Street Address: _____ Fax: _____

City/State/Zip: _____ Phone Number: _____

Referring MD Signature: _____

Reason for Referral (check all that apply): ☐ Weight-Loss Intervention ☐ Bariatric Surgery

☐ Subspecialist _____ ☐ Management of Comorbidities ☐ Other: _____

Diagnosis (check all diagnoses that may apply):

General	Endocrinology	Gastroenterology/ Nutrition
☐ **Obesity, Unspecified**	☐ **Abnormal Weight Gain**	☐ **GERD**
Pulmonary	☐ Metabolic Syndrome	☐ Dyspepsia
☐ **Sleep Apnea**	☐ Diabetes I	☐ Abnormal Liver Function
☐ **Asthma**	☐ **Diabetes II**	☐ Abdominal Pain
Cardiology	☐ Hyperinsulinism	☐ Hepatomegaly
☐ **Hypertension**	☐ Acanthosis Nigricans	☐ Chronic Hepatitis
☐ **High Cholesterol/Lipids**	☐ Gynecomastia	☐ Liver Disease-Non EtOH
Psychological/Psychiatric	☐ Hidden Penis	☐ **Cholelithiasis**
☐ Bulimia Nervosa	☐ Short Stature	☐ Cholecystitis
☐ Binge-Eating Disorder	☐ Rapid/Stunted Growth	Musculoskeletal
☐ Depression	☐ Hypometabolism	☐ **Degenerative Joint Dx**
☐ Anxiety	☐ Polycystic Ovarian Dx	☐ **Osteoarthritis**
☐ Enuresis/ Encopresis	☐ **Amenorrhea**	☐ **Joint Pain**
☐ ADHD	☐ Dysmenorrhea	☐ Back Pain
Neurology	☐ Dysuria	Genetics
☐ Headache	☐ Hirsutism	☐ Prader-Willi
☐ Pseudotumor cerebri	☐ Hypogonadism	☐ Other: _____

Authorization (Consultation + 5 Follow Up Visits are Requested): Required: (YES / NO)

Authorization Number: _____ No. of Authorized Visits: _____ Exp. Date: _____

Insurance ID#: _____ Insurance Plan: _____

Medical Group: _____ Phone: _____

Form Completed by: _____ Phone: _____

FAX Form & Lab Results (Fasting Lipid Profile & Glucose Levels, AST/ALT)

to 310-301-5391 AND 310-206-3566