



Referral Request Form
Pediatric Weight Clinic

Print Clearly

ATTN: REFERRAL CENTER

FAX: (650) 721-2884

PHONE: (800) 995-5724

Referral Date: _____

LPCH MR # _____

From: _____ MD/NP/PA Phone: () _____

Address: _____ City _____ State: _____ Zip: _____

Fax: () _____

Please indicate your relationship to the patient: PCP Other _____

REQUIRED PATIENT INFORMATION:

We need all of the information below filled out completely. This will be sent back to you if not filled out correctly.

Recent Height: _____ cm/in Weight: _____ lbs/kg Calculated BMI: _____ (BMI must be > 95% to qualify for Pediatric Weight Clinic)

Current medical and psychiatric conditions: Diabetes Obstructive sleep apnea Hepatitis NASH Pseudotumor Cerebri
 Thyroid Problems Bipolar Disease Depression ADHD Psychosis **Other (please list):** _____

Current Medications (please list) 1.

2.

3.

4.

5.

Last Name First Name MI DOB AGE

Parent's/Guardian's Name: _____ Phone: C () _____ - _____ W () _____ - _____

Patient's Cell # _____ - _____ Home # () _____ - _____

Patient's Address: _____ City/State/Zip: _____

Reason for Referral: Weight Loss Management Bariatric Surgery Evaluation

Type of Service Requested: Consult and recommend management Follow up Consult and treat
 Bariatric Surgery Evaluation Other: _____

Comments: Family notified of Pediatric Weight Clinic consult.

Authorization required? Yes No # Visits Authorized: _____ Auth # _____

Expiration Date of Authorization: _____ Insurance ID # _____

Insurance Plan: _____ Medical Group: _____ Phone: () _____

Form Completed by: _____ Phone: () _____