



**Referral Request Form**  
**Pediatric Weight Clinic**

**ATTN: REFERRAL CENTER**

FAX: (650) 721-2884

PHONE: (800) 995-5724

Referral Date: \_\_\_\_\_

LPCH MR # \_\_\_\_\_

From: \_\_\_\_\_ MD/NP/PA Phone: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_

Please indicate your relationship to the patient:  PCP  LPCH Specialist \_\_\_\_\_

Other \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**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 **BMI:** \_\_\_\_\_

**Is BMI > 95%? Y** **N** (BMI must be > 95% to qualify for Pediatric Weight Clinic)

\_\_\_\_\_  
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: \_\_\_\_\_

Spanish Speaking Y N: Parent's Email: \_\_\_\_\_@\_\_\_\_\_.

Diagnosis: \_\_\_\_\_ ICD-9: \_\_\_\_\_

Reason for Referral:  Obesity  Weight Loss Management  Bariatric Surgery Evaluation

Additional Information: \_\_\_\_\_

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: ( ) \_\_\_\_\_