DR.PATRICIA
HEALTHY FAMILIES

A Promising Approach to the Prevention and Treatment of Nutrition Related Health Conditions in Children and Adults

Patient Referral Form

Patient Information

Patient Name: ______________________________

Date of Birth: ______________ Age: __ Sex: M/F

Weight: _____________ Height: _____________

BMI: _______________ BP: __________________

Date Measured: ___________________________

Allergies: _________________________________

Medical Hx: _______________________________

Pediatrician or PCP Name: _________________

____

Phone Number: ____________________________

Referred By

Please explain the referral to the parents and obtain consent before sending referral

Name: ____________________________________

Title: _____________________________________

Address: __________________________________

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Phone: ___________________________________

Fax: ______________________________________

E-mail: ___________________________________

Date Referred: _____________________________

Reason for referral / Any additional information: _______________________________

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Parent Name (If pt. <18 yrs)________________

Address: __________________________________

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E-mail: ___________________________________

Language Spoken: __________________________

Does the patient have insurance? Y/N

Name of Health Network:

____

ID Number:

____

Pre-HAB Patient

Surgeon Name: ____________________________

Date of Surgery: ___________________________

Pre HAB concerns: _________________________

Physical activity restrictions: ________________

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Areas of Concerns

- ☐ Underweight / Overweight / Obesity
- ☐ Poor nutrition
- ☐ Picky eaters
- ☐ Hypertension
- ☐ Adult life-style support
- ☐ Failure to Thrive
- ☐ Family history of obesity/ diabetes
- ☐ Feeding dynamic issues
- ☐ Acanthosis nigricans/ elevated HgbA1c
- ☐ Elevated Lipids
- ☐ NAFLD
- ☐ Low Vitamin D
- ☐ Low albumin
- ☐ Diabetes Prevention Program (18 years and older)

Airway (BeWell)

- ☐ Pediatric
- ☐ Adult

For CCS, CHA, CCN, and FC insured children need to be referred by their Primary Care Doctor. **Fax form to (714) 549-6449**. If you are having trouble with this form or have any other question about how to refer a patient, please contact Celeste Montalvo at **Phone: (714) 549-6440** *www.DrPatriciaMD.com*