Dr. Patricia's Health Club

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:_____

Weight: _____ Height: _____

BMI: _____ BP: _____

Date Measured: _____

Allergies: _____

Medical Hx: _____

Address:_____

_____

PCP Name: _____

PCP Phone Number: _____

Parent Name (If pt.<18 yrs)_____

Email:_____

Language Spoken: _____

Parent Phone Number: _____

Does the patient have insurance? Y/N

Name of Health Network:

ID Number:

Referred By

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

Name: _____

Title: _____

Address: _____

_____

Phone: _____

Fax: _____

E-mail: _____

Date Referred: _____

Reason for referral / Any additional information:

_____

_____

_____

_____

Areas of Concern:

- ☐ Special Needs/CCS
- ☐ Housing Insecurity
- ☐ Hospitalization/ED
- ☐ ACEs
- ☐ Food Insecurity
- ☐ Adult life-style support
- ☐ Hypertension
- ☐ Low albumin
- ☐ Behavioral Health
- ☐ NAFLD
- ☐ Poor nutrition
- ☐ Picky eaters
- ☐ Failure to Thrive
- ☐ Elevated Lipids
- ☐ Feeding dynamic issues
- ☐ Underweight / Overweight / Obesity
- ☐ Family history of obesity/ diabetes
- ☐ Diabetes prevention or management
- ☐ Acanthosis nigricans/ elevated HgbA1c

For CCS, CHA, and FCMG insured children and/or adults should 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 us at (714) 549-6440.

www.DrPatriciaMD.com