SAINT JOSEPH MERCY HEALTH SYSTEM

ShapeDown Program for Weight Management Referral Form

For Physician Office Referral Coordinator or Medical Office Staff

734-712-5694 • Fax: 734-712-5499 • Email: darnellb@trinity-health.org

Physician	Patient
Name: _____	Name: _____
Address: _____	DOB: _____
_____	Parent Name: _____
_____	Parent Phone: _____
Phone: _____	Parent e-mail:: _____
Fax: _____	Insurance: _____

Physician Office Referral Coordinator:

Your patient is planning to enroll in the next ShapeDown Session 10-week weight management program for children, adolescents and parents. Please complete this form and return by fax to 734-712-5499 so we can best serve your patient.

Please attach:

1. ***Growth curve***
2. ***Summary of weights***
3. ***Notes from last visit regarding obesity including any pertinent labs performed.***

Reason for Referral:

❑ E66.9 Childhood Obesity BMI ≥ 95%	❑ R73.09 Pre-diabetes (other abnormal glucose)
❑ E66.3 Overweight Child BMI ≥ 85% and < 95%	❑ E11.9 Diabetes, type 2 without complications
❑ Z71.3 Dietary Surveillance	❑ E78.5 Hyperlipidemia, unspecified
BMI Percentile Codes (to be used with above E codes)	❑ I10 Essential Hypertension
❑ Z68.54 Childhood Obesity ≥ 95%	❑ J45.909 Unspecified asthma, uncomplicated
❑ Z68.53 Overweight Child BMI ≥ 85% and < 95%	❑ Other:

This patient has emotional difficulties or family problems that may affect his/her participation in this intervention:

Yes_____ No_____ If yes, please describe:_____

I approve of my patient's partaicipation in the ShapeDown Program at this time.

Physician Signature:_____ ***Date:*** _____ ***Time:***_____

For more information contact, Beth Darnell, ShapeDown Coordinator at 734-712-5694 or visit stjoeshealth.org/shapedown

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