



Goshen Physicians

CENTER FOR WEIGHT REDUCTION

Fax – New Patient Referral Form

Attention:

From:

Fax number: 574-534-0836

Today's Date:

Total pages,
including cover:

Phone number:

Please complete this form and fax . **All new patients are required to attend a free new patient informational seminar.** Goshen Physicians Center For Weight Reduction will contact the patient to schedule the seminar. The initial consultative appointment will be scheduled at the seminar. This ensures patient understanding and commitment to the lifestyle changes needed to be successful in the Goshen Physicians Center For Weight Reduction programs. **Please fill out completely for your patient to receive the best service.**

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

Address: _____ E-Mail: _____

City: _____ State: _____ ZIP: _____

Home #: _____ Cell #: _____

Primary Insurance: _____ Secondary Insurance: _____

ID#: _____ Group #: _____ ID#: _____ Group #: _____

Provider Services Phone #: _____ Provider Services Phone #: _____

Reason for Referral: _____

PATIENT HEALTH HISTORY:

Height: _____ Weight: _____ BMI: _____

Medical History/Co-morbidities (please check all that apply): Acid Reflux (GERD) Arthritis

Diabetes – Type 1 Diabetes – Type 2 High Cholesterol Hypertension Obstructive Sleep Apnea

Other (please describe any other medically relevant conditions): _____

PROVIDER INFORMATION:

Referring provider: _____ Form completed by: _____

Referring provider fax #: _____

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