***Apex Metabolic***

**Medical Weight Loss Referral Form**

Dear Doctor,
Thank you for your kind referral to Apex Metabolic, LLC. To begin our evaluation process please complete this form and return it to **us using one of the methods below**. Call **614-383-0847** with any questions regarding this form.

1. Fax: 614-363-1388
2. Mail: Apex Metabolic, LLC
   4000 Lead Rd
   PO Box 70
   Hilliard OH 43026

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**Patient Name:** **DOB:**

Parent/Guardian Name:

Address:

Phone: Email:

**Referring Clinician:** Primary Specialty:

Address

Phone: Fax: Email:

How long have you been treating this patient?

***Date of last appointment:** **Height (inches):** **Weight (pounds):**

**Primary Insurance Carrier:** **ID Number:**

**Insurance Phone & Contact:**

**** Please send a copy of the patient's insurance card along with the completed referral form***

**Current Co-morbidities (check all that apply):**

| | | |
|---|---|---|
| ☐ Diabetes | ☐ Heart Disease | ☐ Polycystic Ovary Syndrome |
| ☐ Abnormal lipid panel | ☐ Fatty Liver Disease | ☐ Impaired ADLs |
| ☐ Hypertension | ☐ Menstrual Changes | ☐ Heartburn |
| ☐ Sleep Apnea | ☐ Joint Pain | ☐ Asthma |
| ☐ Insulin Resistance | ☐ Pseudotumor Cerebri | ☐ Gallstones |
| ☐ Depression | ☐ Stress Urinary Incontinence | ☐ Soft Tissue Infections |

**Primary reason for referral:**

**Important Note: It would be helpful to enclose clinic notes (weight management or dieting attempts), documentation of co-morbidities, recent lab results, sleep study report, oral glucose tolerance test results, copies of consultant reports.**

**Your signature below indicates that you are requesting that we evaluate your patient for medical, non-operative weight loss attempts.** Feel free to call **614-383-0847** if you have any other information which might be helpful for our evaluation of this patient or if you have any questions or concerns

Signature: _____ Date: _____