Weight Management Referral Form

Fax to (951) 280-8218

A. Patient Information

Please verify patient's current address and phone number.			
Name:			Date of referral:
DOB:	Sex: ☐ ☐	Language: ☐ ☐	
Address:			
City:	Zip code:	Phone number: ☐ ☐	
Height (in):	Weight (lb):	BMI:	Diabetic: Y N
If patient is a minor, please provide name and language of parent/legal guardian.			
Name:		Language: ☐ E ☐ S ☐ Other:	
Diagnosis (include ICD-9 code) / Notes:			

B. Service Requested

Service requested:

C. Provider Information

Provider name:	
Person completing referral (if other than provider):	
Phone number:	Fax number:

Vantage Medical Group Health Education use only	
Provider notification date:	