|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MEDICAL FITNESS SERVICE REFERRAL FORM** | | | | | | |
| **Patient Info:** \*Click on grey areas to enter data | | | | | | |
| Name: | | | | DOB: | |  |
| Preferred Phone #: | | | | Insurance: | | |
| Email: | | | | Policy #: | | |
|  |  | |  | Prior Authorization Number: | | |
| **Primary Diagnosis code(s):** | | | | | | |
| 1. | 2. | 3. | | | 4. | 5. |
|  |  | |  |  | |  |
| **Referring Provider:** | | | | | | |
| Name:      Daivd Lieb, MD | | | | | |  |
| NPI:      1629286059 | | | Practice Name: | | | |
| Phone: | | | Fax: | | | |
|  |  | |  |  | |  |
| **Health Outcome Measures** | | | | | | |
| Check | Expected Outcome/Measure | | | Notes | | |
| ☐ | **A1c Reduction** | | |  | | |
| ☐ | **Lowering Blood Pressure** | | |
| ☐ | **Increased HDL/Lowered LDL** | | |
| ☐ | **Weight Management (Obesity)** | | |
| ☐ | **Nutrition Education/Guidance** | | |
| ☐ | **Pain Management** | | |
| ☐ | **Remote Patient Monitoring (select)**   * **Glucose** * **Weight** * **Blood Pressure** * **Pulse Oximetry** | | |
|  |  | |  |  | |  |
| Check | Frequency | |  | Check | | Duration |
| ☐ | 3X Week | |  | ☐ | | 3-6 months |
| ☐ | 2X Week | |  | ☐ | | 8 Weeks (refill) |
|  |  | |  |  | |  |
| **Important:** Please submit *supportive clinical documentation* to substantiate the medical necessity for service including but not limited to: H&P, office notes, laboratory and imaging results, and skilled therapy notes. | | | | | | |
|  | | | | | | |

|  |  |
| --- | --- |
| Provider Signature: | Date: |
|  |  |
| ***WHERE EXERCISE AND NUTRITION IS MEDICINE*** | |