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