Children's Hospital LOS ANGELES

EMPOWER WEIGHT MANAGEMENT CLINIC

EMPOWER Weight Management Clinic **Please FAX to 323-617-5658**
Physician Referral Form

Date of Referral____/_____/_____
Patient Name_____
Date of Birth_____/____/_____
CHLA MRN#, if available_____
****Please note, Alta Med patients should be referred to Alta Med weight management services****

Parent 1_____Parent 2_____
Parent Contact Information (preferred method(s), phone/address/email)
_____ _____
_____ _____
_____ _____

Referring Physician: Name_____
Address_____Phone_____
_____ Fax_____

Patient Height_____Weight_____BMI_____BMI Percentile_____Date of exam:_____
(BMI Percentile must be > 85th for Referral to be Accepted)

Identified Co-Morbidities:

- ☐ Hypertension
- ☐ Type 2 Diabetes Mellitus
- ☐ Impaired Fasting Glucose
- ☐ Impaired Glucose Tolerance
- ☐ NAFLD
- ☐ Snoring
- ☐ Obstructive Sleep Apnea
- ☐ Hyperlipidemia
- ☐ PCOS

Please attach following labs (required for all children ≥ 5 years, performed within 3 months of the referral date)

- ☐Fasting Glucose
- ☐Fasting Lipid Panel (TC, LDL, HDL, TG)
- ☐TSH
- ☐ALT and AST
- ☐Any other relevant lab work that you have already performed

Please attach:

☐ Recent H+P ☐ Growth Chart ☐ Copy of Insurance Card (front and back)
☐ Initial Evaluation CPT per provider: including one initial visit

Physician	CPT: 99205	1 visit
Registered Dietitian	CPT: 97802	3 units total
Psychologist	CPT: 96150	2 units total
Physical Therapist	CPT: 97001	1 visit

Please verify that patient has been informed that you are referring them to the CHLA weight management clinic and that they agree to referral.

_____ _____
Physician Signature **Date**