



University of Maryland Center for Weight Management & Wellness Initial Contact Form For Referring Physicians

Patient's Name: _____

Address: _____ Date of Birth: _____

_____ Phone Number: (____) _____ - _____

Referring Physician Information:

Name: _____

Address: _____

Phone Number: (____) _____ - _____

Fax Number: (____) _____ - _____

Patient's Height: _____

Patient's Weight: _____ lbs. **OR** BMI= _____

How did you hear about the University of Maryland Center for Weight Management and Wellness?

- Yellow pages Radio Newspaper Television From a friend Joslin Center
- From a physician Dr. _____ Internet site www. _____
- Other _____

Are you interested in referring your patient to:

- * Medical weight loss program (hyperlink: Medical Weight Loss and Wellness Programs) _____
- *Bariatric Surgery (hyperlink: Are you a Candidate for Bariatric Surgery) _____
- *Undecided _____

Note: Completion of this form does not constitute a physician/patient relationship.