



WOODLANDS

MEDICAL SPECIALISTS

WEIGHT MANAGEMENT & WELLNESS

Please Fax Completed Form to **(850) 898-3552**

Patient Name: _____	DOB: _____
Address: _____ City: _____ Zip: _____	
Primary Phone: _____ E-mail Address: _____	
Primary:	
Insurance Company: _____ Policy#: _____	
Group: _____ Policy Holder: _____	
Secondary:	
Insurance Company: _____ Policy#: _____	
Group: _____ Policy Holder: _____	
Referring Provider: _____	
Practice Name: _____	
Phone: _____ Fax: _____	
Diagnosis: _____	
Patient's BMI: _____ Comments: _____	

Please include the following with referral:	
<ol style="list-style-type: none">1. Patient demographic information2. Last progress note3. Previous lab results and EKG from last six months if available<ol style="list-style-type: none">a. Patient will be scheduled for fasting labs and an EKG prior to starting program.<ol style="list-style-type: none">i. Fasting labs will include CBC, CMP, TSH w/reflex, A1C, Lipid panel and Insulin.4. Please list in comments above any reason patient should be scheduled ASAP.	

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Woodlandsweightcenter.com

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