OBESITY CARE MANAGEMENT
Initial Evaluation Form

Date of Initial Appointment: _____ Healthcare Provider Name:_____

Member Name: _____ PEBP ID: _____

Patient DOB: _____ Current Weight:____ Height:_____ BMI: _____

Diagnosis/Co-morbidities:

_____

_____

_____

Lab Work Completed at Initial Visit:

Test	Value	Date of Test
Blood Pressure		
Cholesterol HDL		
Cholesterol LDL		

1. Will meal replacement be part of therapy? Yes No
2. Will prescription medication be part of therapy? Yes No
3. Are you recommending this patient join your obesity care management program? Yes No

I, the undersigned, hereby certify that I am the named member's healthcare provider and I certify that I have examined the named member sufficiently to answer the above questions. Further, I certify that the above answers are true and accurate statements regarding the named member's wellness, weight and activities.

_____

Healthcare Provider