Arkansas Children's Hospital
Weight Management Clinic
Referral Form

Arkansas Children's
HOSPITALS • RESEARCH • FOUNDATION

Referral Date:_____ACH MR#:_____

Diagnosis:_____ICD:_____

Please Fax to: 501−364−5440

Required Practitioner Information	
Practitioner Name:	
Practitioner Phone Number: ( ) −	Fax Number: ( ) −
Office Name:	
Required Caregiver Information	
Patient Caregiver's Name:	
Address	❑ Home ❑ Cell Phone Number: ( ) −
Required Patient Information	
Last Name:	First Name:
Middle Initial:	Date of Birth: / / Age:
Weight: Date taken:	Height: Date taken:
BMI must be > 97%ile or greater than 85%ile with a co−morbidity in order to qualify for this clinic	
BMI:	Percentile BMI:

Co−morbidities:

- ❑ Heart Disease
- ❑ Hyperlipidemia
- ❑ Hypertension
- ❑ Lung Disease
- ❑ Non−Alcoholic Fatty Liver Disease
- ❑ Acanthosis Nigricans
- ❑ Emotional or Behavioral Concerns
- ❑ Obstructive Sleep Apnea
- ❑ Orthopedic Conditions
- ❑ Polycystic Ovarian Syndrome
- ❑ Pseudotumor Cerebri
- ❑ Other: _____

Reason for Request/Specific Questions to be Answered:

REQUIRED Information before appointment can be scheduled

❑ Copy of Fasting Labs: (Glu, Trig, Total Chol, LDL, HDL, Insulin, AST, ALT, VIt D 25)

Form Completed by: _____Date: _____Time:_____

INTAKE.REF.WTMG