Healthy You for Life Program
Physician Prescription Form

PATIENT'S NAME_____Age _____DOB_____

Parent/Guardian name_____DOB_____

Phone #_____Cell _____ Work_____

Mailing Address_____

Weight _____Height_____BMI%_____ Male / Female Race_____

How much weight has this patient gained over the past year? _____ MR#_____

DIAGNOSIS (please check all that apply)

____	Abnormal Weight Gain	R63.5	____	Obstructive Sleep Apnea	G47.33	____	Depressive D.O. NOS	F32.9
____	BMI >85 - <95 %	Z68.53	____	Sleep Disturbance	G47.9	____	Anxiety D.O. NOS	F41.9
____	BMI >95 %	Z68.54	____	Snoring	R06.83	____	ADHD NOS	F90.9
____	Metabolic Syndrome	E88.81	____	Acanthosis Nigricans	L83	____	Hypertension, essential	I10
____	Hypercholesterolemia	E78.0	____	Impaired Fasting Glucose	R73.01	____	Elevated Blood Pressure	R03.0
____	Mixed Hyperlipidemia	E78.2	____	Impaired Glucose Tolerance Test	R73.02			
____	Hyperlipidemia NOS	E78.5	____	Asthma Extrinsic	J45.909	____	Ankle Joint Pain	M25.57
____	Hypertriglyceridemia, essential	E78.1				____	Hip Joint Pain	M25.55
						____	Knee Joint Pain	M25.56
			____	Urinary Incontinence	R32	____	Low Back Pain	M54.5
____	Reflux, Esophageal	K21.9	____	Amenorrhea	N91.2	____	Pes Planus (Flat Foot) RIGHT	Q66.51
____	Elevated LFTs	R74.0	____	Oligomenorrhea	N91.5	____	Pes Planus (Flat Foot), LEFT	Q66.52
____	Steatohepatitis	K75.81	____	Gynecomastia	N62	____	Problem related to lifestyle, unspecified	Z72.9

____ Other _____

LABS DONE WITHIN 6 MONTHS - YES or NO @ CHKD, @ SENTARA, or OTHER _____

Primary Insurance Company _____

Name of Policy Holder _____DOB _____

Subscriber # _____ Group # _____

Relationship to Subscriber _____

Secondary Insurance Company _____

Name of Policy Holder _____DOB _____

Subscriber # _____ Group # _____

Relationship to Subscriber _____

If insurance referral is required by patient's insurance provider, REFERRING physician is responsible for obtaining the referral from insurance company. AUTHORIZATION #_____

The patient will be evaluated by the Healthy You for Life team including:

• The Healthy You Physician • Registered Dietitian• Physical Therapist • Licensed Clinical Social Worker

_____Date_____

Physician's signature / Date ***I certify that the services listed above are all medically necessary.***

_____ /_____

Physician's phone number and name PRINTED Name of Physician Practice

This form may be **FAXED to 668-7809** or mailed with the program registration form.
Questions, please call 668-7035.