SEGER | MD

WELLNESS & WEIGHT MANAGEMENT

New Patient Referral Form

Please complete and fax to 210.807.7470

Date: _____

Patient Name: _____ DOB: _____

Patient Mobile: _____ Patient Email: _____

Reason For Referral: _____

_____

_____

Weight: _____ Height: _____

Co-Morbid Conditions (Check all that apply):

- ☐ Abnormal Weight Gain
- ☐ Heart Disease
- ☐ Fatty Liver
- ☐ High Blood Pressure
- ☐ Joint Pain
- ☐ Obstructive Sleep Apnea
- ☐ Type 2 Diabetes
- ☐ Pre-Diabetes/Insulin
- ☐ Renal Insufficiency/Renal Failure
- ☐ High Cholesterol
- ☐ GERD
- ☐ Other: _____

Referring Physician's
(or Authorized Representative)
Name
(print)

_____

Referring Physician's
(or Authorized Representative)
Signature

_____

Referring Physician's
Phone: _____

Date: _____

Fax: _____

*Please attach copy of insurance card

*Please fax any patient labs, diagnostic testing, last office visit or notes