



MassGeneral for Children™
at Newton-Wellesley Hospital

Adolescent and Young Adult Obesity Medicine Weight Management Program Referral Form

2014 Washington Street – 6 South, Newton, MA 02462

Phone: 617-643-1201

Fax: 617-243-6798

Patient Name: _____ MGH #: _____

Date of Birth: ___ / ___ / ___ MWH #: _____

Referring Provider Information:

Referring Provider Name: _____

Practice Name/Location: _____

Office Phone: (_____) _____ Fax: (_____) _____

Email: _____

PCP Name (if not referring provider): _____

PCP Practice Name/Location: _____

PCP Phone: (_____) _____ Fax: (_____) _____

PCP Email: _____

Patient Weight Information:

Weight: _____ pounds Height: _____ inches BMI: _____

Patient Medical Problems: (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> PCOS | <input type="checkbox"/> Hyperinsulinemia/Insulin resistance |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Glucose intolerance | <input type="checkbox"/> GERD | <input type="checkbox"/> School/Social Problems |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fungal rashes |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Knee Pain | |
| <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Other joint pain: _____ | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fatty liver disease | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Other: _____ | |

Treatments to consider: (check all that apply)

- Behavioral treatment program (diet/exercise/behavioral modification)
- Weight loss medications
- Weight loss surgery
- Other: _____

Special Considerations: _____

Please fax completed form to (617) 243-6798.