Brenner FIT®

Brenner Children's

Referral Form

FAX Referral Form to: 336-713-7841

QUESTIONS?

EMAIL: Brennerfit@wakehealth.edu

CALL: 336-713-BFIT (2348)

PATIENT INFORMATION

Patient: _____
Last Name First Name

Date of Birth: _____ **MRN#** _____

Parent/Guardian: _____
Last Name First Name

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: _____
□ Yes you can text this number

Secondary Phone: _____
□ Yes you can text this number

Parent Email: _____

Parent/Patient Preferred Language: _____

Interpreter **Needed?** □ Yes □ No

Patient Height: _____ **in/cm** **BMI:** _____ **kg/m2**

Patient Weight: _____ **lbs/kg** **BMI:** _____ **%ile**

REFERRING PROVIDER INFORMATION

Date of Referral: _____

Provider Name: _____
Last Name First Name

Provider Specialty: _____

Provider Email: _____

Practice Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Patients do NOT have to have a comorbidity to qualify for Brenner FIT®.

It is recommended they check with their insurance provider to ensure obesity and/or weight management is a covered service.

Please check all that apply and/or fax all laboratory values available

Co-Morbidity	Lab Value	Normal Value	Date Obtained
□ Hypercholesterolemia	_____ Total Cholesterol	(< 200mg/dL)	_____ Date
□ Dyslipidemia	_____ HDL	(> 40mg/dL)	_____ Date
□ Hyperlipidemia	_____ LDL	(< 130mg/dL)	_____ Date
□ Hypertriglyceridemia	_____ Triglycerides	(< 130mg/dL)	_____ Date
□ Acanthosis Nigricans	_____ Hemoglobin A1c	(<5.7%)	_____ Date
□ Pre-diabetes **(Hemoglobin A1c between 5.7% - 6.4%)**	_____ Fasting Glucose	(< 100mg/dL)	_____ Date
□ Type 2 Diabetes	_____ AST	(≤ 60 U/L)	_____ Date
□ Elevated LFTs /NAFLD/NASH	_____ ALT	(≤ 60 U/L)	_____ Date
□ Hypertension (Systolic or diastolic BP > 90th percentile on 3 readings)			
BP_____ **Date**_____			
BP_____ **Date**_____			
BP_____ **Date**_____			
□ Sleep Apnea			
□ Pseudotumor Cerebri			
□ Blount's Disease/SCFE			
□ Asthma			