Wise Choices Referral for Medical Evaluation

Client Name _____ Birth Date _____ MBCIS ID_____

Referred to _____ Phone # _____ Fax #_____

Referred by _____ Phone #_____

Reason(s) for Referral: ❑ Elevated Blood Pressure_____ ❑ Elevated Total Cholesterol_____
❑ Elevated Glucose_____ ❑ Undesirable HDL Cholesterol_____

(See attached Screening Form and/or laboratory report for the clinical values related to the referral.)

Client Medical Evaluation Appointment Date: _____/_____/_____

Notes to Provider:

_____

_____

_____

_____

❑ Client needs physical activity clearance

_____ _____
Signature Date

TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Medical Evaluation _____/_____/_____ BP on Date of Evaluation _____/_____

Medical Evaluation Results and Plan of Care. (Include any medications prescribed or changes to medications.)

❑ Medication _____

_____

_____

❑ Other treatment_____

_____

Client cleared for Physical Activity ❑ Yes ❑ No

_____ _____
Signature of Health Care Provider Date

Check the box of the Office Visit CPT Code for which you plan to bill. Please check ONE box only.						
New	❑ 99201	❑ 99202	❑ 99203	❑ 99204	❑ 99386	❑ 99387
Established	❑ 99211	❑ 99212	❑ 99213	❑ 99214	❑ 99396	❑ 99397

RETURN REPORT BY FAX_____ ATTENTION: _____