Provider Supervised Weight-loss Checklist

Member Name: _____ DOB: _____ AGE: _____

Health Plan: _____ LOB: _____ ID#: _____

PCP Name: _____ Tel: ( ) _____-_____

******************TO BE COMPLETED BY CLINICAL STAFF ONLY*******************

1. Weight at last visit: _____ Current Weight: _____ Weight Change: _____

   Current Height: _____ Current BMI: _____

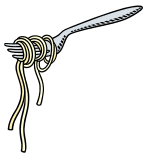
2. Blood Pressure: _____ Waist Measurement: _____ Heart Rate: _____

3. Dietary Recommendations: ☐ 1200 Calorie Diet ☐ 1500 Calorie Diet ☐ D.A.S.H. Diet

4. Review "Bad Food" Checklist: _____

   ☐ Fast Food 

   ☐ Soft Drinks 

   ☐ Carbohydrates 

   ☐ Desserts 

   ☐ Other 

5. Physical Activity:
   a. What Type? _____
   b. Frequency: _____
   c. Goals: _____

6. Behavioral Modifications: _____
   _____

7. Pharmacotherapy:

Drug	Trial Period	Comments

***Please include visits notes with any additional comments.**

_____ _____

Please Print Name of Certifying Provider **Date**

_____ _____

Supervising Physician's Signature **Date**

*IEHP requires Member Participation in a Weight Management Program or a Provider Supervised Office Program
*Pharmacological Treatment can be approved as any stage of Weight Management Program Involvement