new U Columbia Optimal Health

A Physician Referral Program focusing on Exercise, Nutrition and Behavioral Health

Fax to
443-283-4247
Attention
Shawni Paraska
Phone
410-715-3128

Medical Evaluation & Referral Form

Participant's Name_____

Date of Birth_____

Day Phone Number_____

Evening Phone Number _____

Cell Phone Number_____

Email Address_____

Height_____ Weight_____ % Fat_____ BMI_____

Neck Circumference_____ Resting Pulse_____

Pulse Ox_____ Blood Pressure_____

Abd. Girth_____

HENT & Neck_____ CVS_____ Chest_____ Abdomen_____

8 hour fasting glucose_____ Fasting Cholesterol_____

TG_____ HD_____ LDL_____ Ratio TC/HDL_____

Recommendations for patient participation in Columbia Optimal Health: _____

_____

_____

I find no medical contraindication to participating in Columbia Optimal Health. Physician Referral Form, from the office of:

_____

Referring Healthcare Professional (PLEASE PRINT)

_____

Signature **Date**

I give permission for the medical office listed above to fax or mail this Medical Evaluation and Referral Form to the Columbia Optimal Health Program representatives.

_____

Patient (PLEASE PRINT)

_____

Signature **Date**

Columbia Association