

## Weight Loss / Smoking Cessation Medical Evaluation and Clearance

Must be completed within 90 days of enrollment by PCP \_\_\_\_\_

### Clinical & Lab evaluation:

Height, in	_____	Date	_____
Weight, lb	_____	Date	_____
BMI, kg/m <sup>2</sup>	>25 _____ >30 _____ >40 _____	Date	_____
Blood Pressure, mmHg	_____	Date	_____
Fasting Blood Glucose	_____	Date	_____
TC, mg/dl	_____	Date	_____
LDL, mg/dl	_____	Date	_____
HDL, mg/dl	_____	Date	_____
Triglycerides	_____	Date	_____
TSH	_____	Date	_____
EKG (within 6 months)	_____	Date	_____
Stress test, if indicated, for cardiovascular assessment / disorder or exercise tolerance	_____	Date	_____
Medical clearance (within 30 days)	_____	Date	_____

Able to devote 15-30 mins of exercise/day x 6 months	Yes	_____	No	_____
Medically stable to proceed with weight loss / smoking cessation program as planned	Yes	_____	No	_____

Please provide copies of all testing done as per requirements one week prior to enrollment consult.

Referring MD Signature \_\_\_\_\_

Medical License # \_\_\_\_\_

Phone \_\_\_\_\_

**Please complete and fax to Gina Sweat at 954-659-5256.**