Non-Surgical Weight Loss Program

This program will be open to anyone over the age of 18 who is interested in losing weight.

The program will not only provide participants with a dietary plan for weight loss but will also provide tools for effective psychological behavior modification.

Before the participant can enter the weight loss program, medical clearance need to be obtained either from the participant’s own PCP or any CCF internist. The “Weight Loss Medical Evaluation and Clearance” form must be completed by the PCP and reviewed by a CCF internist before the participant can schedule the initial appointment with the psychologist and dietitian.

If CCF accepts participant’s insurance, the internist visit for clearance can be billed through the insurance. Should the participant wish to pay out-of-pocket to have the clearance done with the internist, the fee is $100.

The program will run for 9-weeks. The appointment will be done one-on-one on Wednesday with the dietitian (60 minutes) and the psychologist (75 minutes). These will be schedule back-to-back.

Appointments 2 thru 9 will be in a group setting and will meet on Monday for 60 minutes with the nutritionist and for 60 minutes with the psychologist. These group appointments will also be back-to-back. Participants will register at desk 21/22 to get weighed in by the dietitian. The groups will be held in a David Jagelman Center conference room.

The fee will be $600 for all 9 weeks of both services payable at the first visit. This program will not be covered by insurance.

For additional information call:

Gina Sweat MS, RD, LD/N
954-659-5874

Weight Loss / Smoking Cessation Medical Evaluation and Clearance

Must be completed within 90 days of enrollment by PCP ________________

Clinical & Lab evaluation:
Non-Surgical Weight Loss Program Medical Evaluation and Clearance

Name:____________________________________

Height, in______________ Date:_____________
Weight, lb _____________ Date:_____________
BMI kg/m2 : >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_________

Date:_____________

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_____________________   Phone#________________
Medical License # _______________