

6 Month Medically Supervised Weight Loss Documentation

(Most Insurance companies require that the Office Visit Notes from EACH of the individual, consecutive appointment dates also be included with this form)

Name: _____ DOB: _____

Email address: _____ Daytime Telephone # : _____

Diet Plan: _____

Exercise Plan: _____

Date	Weight	Notes
<u>Start date of diet</u> Month / Day / Year	Lbs.	Specific Nutrition Education Discussed: _____ Specific Exercise/Activity Education Discussed: _____ List Behavior/Diet Goals for this Patient: _____ _____ _____
<u>1 month follow up</u> Month / Day / Year	Lbs.	Specific Nutrition Education Discussed: _____ Specific Exercise/Activity Education Discussed: _____ List Behavior/Diet Goals for this Patient: _____ _____ _____
<u>2 month follow up</u> Month / Day / Year	Lbs.	Specific Nutrition Education Discussed: _____ Specific Exercise/Activity Education Discussed: _____ List Behavior/Diet Goals for this Patient: _____ _____ _____
<u>3 month follow up</u> Month / Day / Year	Lbs.	Specific Nutrition Education Discussed: _____ Specific Exercise/Activity Education Discussed: _____ List Behavior/Diet Goals for this Patient: _____ _____ _____
<u>4 month follow up</u> Month / Day / Year	Lbs.	Specific Nutrition Education Discussed: _____ Specific Exercise/Activity Education Discussed: _____ List Behavior/Diet Goals for this Patient: _____ _____ _____
<u>5 month follow up</u> Month / Day / Year	Lbs.	Specific Nutrition Education Discussed: _____ Specific Exercise/Activity Education Discussed: _____ List Behavior/Diet Goals for this Patient: _____ _____ _____
<u>6 month follow up</u> Month / Day / Year	Lbs.	Specific Nutrition Education Discussed: _____ Specific Exercise/Activity Education Discussed: _____ List Behavior/Diet Goals for this Patient: _____ _____ _____

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Telephone # : _____