H.E.R.O.E.S Weight Related Illness Clinic

Children's HOSPITAL & MEDICAL CENTER
We know children.

PHYSICIAN REFERRAL FORM **FAX TO: Omaha 402-955-4078 OR Lincoln 402-955-8799**

Patient Name: _____Date of Birth:_____/_____/_____
Parent(s)' Names: _____
Parent(s)'Address:_____
_____
Phone Number:_____ Male □ Female □
Preferred Language_____ Does the family need an interpreter? Yes □ No □
Physician Completing Form: _____Physician group_____
Physician Phone Number: _____ Fax Number: _____

REQUIRED PATIENT INFORMATION: *(Necessary in order to accept this referral)*
Recent Height: _____cms Recent Weight: _____kgs. BMI: _____
BMI must be greater than 95% or greater than 85% with a co morbidity in order to qualify for this clinic.

Lab results /diagnostic testing Please include when faxing the referral form:
• Any labs or test results within the last 6 months

☐ HGB AIC ☐ Chem 14 ☐ Fasting Lipid Panel ☐ TSH ☐ Other

☐ Most recent H & P and last clinic note ☐ Immunization Record ☐ Growth Chart
Diagnosis: _____ICD-10: _____

Reason for Referral: ☐ Obesity ☐ Weight Loss Management ☐ Bariatric Surgery
Additional information: _____

Type of Service Requested

☐ Consult and recommend management ☐ Consult and treat ☐ Bariatric Surgery ☐ Evaluation

☐ Follow-up ☐ Other Is family aware of consult for the HEROES Clinic? ☐ YES ☐ NO

Insurance Information *Please include a copy of the insurance card if available*
Plan Name: _____ ID # _____
Group # _____Plan Address: _____
Plan Phone Number: ( ) _____ Plan Fax Number: ( ) _____.

Contact information
HEROES Clinic, Attn: Nurse Case Manager, Omaha office Fax 402-955-4078 Phone 402-955-4080
Lincoln office Fax: 402.955.8799 • Phone: 402.486-1513

Please Sign
I certify that I have examined this child and reviewed all test results. I believe that this patient is appropriate for admission into the Children's Hospital & Medical Center HEROES Clinic and does not require hospitalization at this time.
Physician Signature_____

Date _____