Children's Mercy HOSPITALS & CLINICS
www.childrensmercy.org

Weight Management New Patient Information Form

Fax completed form to 816-234-9294

Dear Provider,
Thank you for your referral to the Weight Management Screening clinic. In order to fully evaluate your patient, **FASTING** lab studies (see separate sheet) and GROWTH CHART / BMI CHART are needed to schedule an appointment in the Weight Management Screening Clinic. **Please complete and fax this form to (816) 234-9294.** Please call our clinic office at (816) 234-9255 with any questions about the referral process.

Patient name: DOB Male Female CMH Medical Record No.

Parent/Guardian: Daytime Phone # Cell #

Address:

City/State/Zip: Translator Needed? Y N Language:

Weight_____(date obtained_____)

Height_____(date obtained_____)

BMI_____ (must be 95% or greater for referral to Weight Management Clinic)

Referring Physician: Phone: Fax:

Reason for referral:

Labs will be done at CMH Y N (circle one)

Insurance:

Today's date:

Dear Provider,

Please complete this form, and FAX it to the lab or give it to your patient to take with them to the lab. Thank you for your referral to the Weight Management Screening clinic. In order to fully evaluate your patient, the following FASTING lab studies and GROWTH CHART/ BMI CHART are needed prior to the clinic visit. If your patient's insurance plan allows, the benefit level is acceptable and transportation is not a barrier, we would prefer that the labs are obtained at a Children's Mercy Hospital location. This will help minimize delays in receiving lab results and facilitate access to lab results while we see the patient in clinic. Please call our clinic coordinator at (816)234-9244 with any questions about the recommended lab below. **Please FAX the lab order below to a CMH lab, or if the lab is obtained elsewhere, please FAX the results as soon as they are received to (816) 234-9294.**

Patient Name_____ **Patient date of birth**_____

Must be FASTING 12 hours prior to draw*

Diagnosis: ☐ **Obesity (278)** ☐ **Polycystic Ovary Syndrome (256.4)** ☐ **Other**_____

☑ **Insulin** ☑ **BMP** ☑ **Lipid Profile** ☑ **Liver Function Tests** ☑ **HbA1C**

If your patient has signs of Polycystic Ovary Syndrome such as hirsuitism or amenorrhea, please also obtain:

☐ **17- OH Progesterone** ☐ **DHEAS** ☐ **Androstenedione** ☐ **L-Wrist Bone Age**

Provider Signature: _____ Date: ___/___/____
Provider Name (printed): _____
Provider phone: _____

The following CMH laboratory locations are available:

Children's Mercy Downtown 2401 Gillham Rd, Kansas City, MO 64108 **Outpatient Lab**: Monday-Friday Lab Hours: 7a.m.- 7p.m. (Enter through Main Entrance) Phone (816) 234-1530 (Outpatient) Fax: (816) 234-1531	**Children's Mercy South** 5808 W. 110th Street, Overland Park, KS 66211 Phone: (913) 696-8210 Fax: (913) 696-8021 Lab Hours: Monday-Friday 8:30a.m.-6p.m. Saturday 9a.m.-1 p.m.
Children's Mercy Downtown 2401 Gillham Rd, Kansas City, MO 64108 **Main Lab**: 24 hours a day, 7 days a week (Enter through Emergency Room) Phone (816) 234-3230 Fax: (816) 234-3794	**Children's Mercy North** 501 NW Barry Road Kansas City, MO 64144 Phone: (816) 413-2520 Fax: (816) 413-2530 Lab Hours: Monday 7:30a.m. - 5p.m. Tuesday-Friday 8:30a.m.-5 p.m.