Salem Health
Hospitals & Clinics

Physician Supervised Non-Surgical Weight Loss Program Form

Instructions: Patient presents this form at each visit with their Primary Care Physician.
This patient's insurance requires ____ consecutive monthly visits that include the discussion points below.

Today's date: _____ Required visit #: _____ of _____

Patient Name: _____ Date of Birth: _____

Today's Weight: _____

REQUIRED DISCUSSION ITEMS:

1. Details of supervised diet plan:

Is patient using a food journal? Y/N
Suggestions for diet modifications:

2. Details of supervised exercise/activity plan:

Is patient using an exercise/activity journal? Y/N
Suggestions for exercise modifications:

3. Details of behavior modification/lifestyle changes:

Suggestions for continued behavior modification/lifestyle changes:

4. Assignments and follow-up for next appt:

Physician Name (Print): _____ Phone #: _____

PHYSICIAN SIGNATURE: _____

Upon completion, please fax to Salem Hospital Bariatric Surgery Center at 503-814-5469.

Patient please retain a copy for your records.