GP/Specialist Approval Form

HWFL™
HEALTHY WEIGHT FOR LIFE

APPLICANT CONSENT

This section must be completed and signed by the applicant.

I, ______________________ wish to enrol in a Healthy Weight For Life Program.

I consent to my name and member number being shared with my health fund to ascertain policy eligibility for the program. I understand that aggregated and deidentified reports of changes to BMI, health status and satisfaction scores may be shared with my health fund (or their authorised agency) for the purposes of assessing and reporting on the effectiveness of the program. I also consent to my referring doctor receiving status reports on my progress as required.

Date of birth: / / Gender: ☐ Male ☐ Female ☐ Other

Phone: Email:

Health Fund: Membership no.

Applicant signature: Date: / /

GP / SPECIALIST APPROVAL

Weight (kg): Height (cm):

BMI (kg/m²): Waist circumference (cm):

Applicant is also being treated for, or has a history of : *(where relevant)*

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Angioplasty or stent
- ☐ Heart attack / stroke
- ☐ Cardiac arrhythmia
- ☐ Type 2 Diabetes
- ☐ Knee or hip osteoarthritis
- ☐ Other *[please specify eg. mental health, respiratory, infertility, gastrointestinal, other musculoskeletal conditions]*

As the applicant is on the following medications, we have discussed that they may require closer medical supervision, and dose adjustments may be necessary.

[please tick all relevant or attach medication list to signed referral form.]

- ☐ Insulin
- ☐ Oral Hypoglycaemics
- ☐ Warfarin
- ☐ Antihypertensives
- ☐ Other

In my opinion it is medically appropriate and safe for this patient to actively lose weight and engage in low intensity physical activity eg. walking, swimming or cycling.

Phased use of meal replacement Some of the Healthy Weight For Life programs include the phased use of KicStart VLCD meal replacements. When included the most intensive phase is 6 weeks utilising a maximum of 2 meals replaced per day. Please indicate if the use of meal replacement is NOT medically suitable for your patient.

☐ meal replacement strategies NOT suitable

Doctor name, address, phone and provider number
[please print or stamp]

☐ GP ☐ Specialist

☐ Please send me a status report on my patient upon completion or discontinuation *(optional)*

Doctor signature: Date: / /

RETURNING FORM

Please send this completed and signed to Prima Health Solutions

Photograph/scan then **email** to **hwfl@hwfl.com.au** **OR** **fax** to (02) **9938 5090.**

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