Specialist Medical Referral Form

HWFL™
HEALTHY WEIGHT FOR LIFE
Osteoarthritis Management

ELIGIBILITY CRITERIA

To be completed by referring medical practitioner

☐ I confirm that the below named patient has a BMI of ≥ 28 kg/m² and diagnosed osteoarthritis of the knee or hip. *[please tick]*

The below named patient fits into the following category: *[please tick one option]*

☐ **Intensive non-surgical management** – primary or revision joint replacement surgery is not yet indicated but I would like my patient to lose weight, improve fitness and muscle strength to enhance their ongoing osteoarthritis management.

OR

☐ **Fitter for surgery** – joint replacement surgery is planned and I would like my patient to lose weight, improve fitness and muscle strength prior to surgery.

Referring Medical Practitioner - in my opinion it is medically appropriate and safe for this patient to start this Program.

Doctor Signature:

Date: / /

Doctor name, address, phone & provider no. *[please print or stamp]*

PATIENT INFORMATION

First Name: Surname:

Date of birth: / / Sex: M / F Height (cm): Weight (kg):

Phone: Email:

Health Fund: Membership no. Suffix (where available):

I agree with the management goals and wish to enrol in the **Osteoarthritis 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 & satisfaction, and symptom 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.

I have reviewed the program website or brochure: ☐ Yes ☐ No

Patient Signature: Date: / /

PARTICIPATING FUNDS

AAMI | ACA Health Benefits Fund | AIA Health | Apia | Bupa | CBHS | Defence Health | Doctors' Health Fund | Emergency Services Health | Frank | GMHBA | GU | HBF | HCF | Health Care Insurance | Health Partners | HIF | ING | Navy Health | nib | Nurses and Midwives Health | Onemedifund | Peoplecare Health | Phoenix Health Fund | Police Health | Qantas | Queensland Country Health Fund | RBHS | Suncorp | Teachers Health | TUH | UniHealth | Westfund

RETURNING FORM

Please send this completed and signed referral form to Prima Health Solutions

Photograph/scan then **email** to **oa@hwfl.com.au** **OR fax** to (02) **9938 5090.**
The Healthy Weight for Life Team will be in contact with the patient to complete the enrolment.