Integrative
Weight and Wellness

Medical Clearance Form

Patient Name _____

Date of Birth _____

The above patient desires to participate in the Integrative Weight & Wellness Program which helps participants lose weight by combining physician oversight, expert nutritional education with personal dietary goal setting, customized fitness plans, and options for weight loss medications. Since this patient has one or more pre-existing conditions which may increase the risk to their health, we ask that you complete this form to confirm that the patient may safely participate in the Weight & Wellness Program.

Physician Name (printed): _____ Phone: _____

Practice Address: _____ City/State: _____ Zip: _____

Medical History

Date of Initial Visit: _____ Date of Most Recent Visit: _____

Condition(s) being treated: _____

Symptoms: _____

_____

Prescribed treatment: _____

_____

Prognosis: _____

_____

Last vitals: Wt: _____ Ht: _____ BP: _____ HR: _____ Temp: _____

Critical Lab Findings: _____

_____

Physician Clearance

The patient is cleared to participate in the Integrative Weight & Wellness Program with the following restrictions: _____

_____

The patient, if desired, may use medication weight loss therapy in conjunction with the lifestyle modifications encouraged during the program. ❑ YES ❑ NO

_____ _____

Provider Signature *Date*

Integrative Rheumatology, PLLC

10826 Mallard Creek Rd, Ste 100 ◆ Charlotte, NC 28282 ◆ Phone: 704.582.5880 ◆ Fax: 704.496.2255

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