Empowered Medicine
Health and Medicine Coaching
Patient Referral Form

PATIENT NAME: _____ **DATE:** _____

DATE OF BIRTH: _____ **REFERRING PROVIDER:** _____

REFERRING PROVIDER PRACTICE NAME: _____

SPECIALTY (endocrinology, Primary care…etc): _____

REFERRING PROVIDER PHONE: _____ **PROVIDER FAX:** _____

PATIENT ALLERGIES

DRUG & SUPPLEMENT ALLERGIES	ALLERGIC REACTION

PLEASE ATTACH A COPY OF:

1. **Facesheet**
2. **Current Medication List**
3. **Current H&P (Or something that shows active diagnosis)**
4. **Last Visit Note**

REASON FOR REFERRAL (Check all that apply)

REASON	Check all that apply	COMMENTS
Understanding medications (indications, dose, timing, side effects)	☐ Yes	
Setting up medications for successful administration	☐ Yes	
Insulin management (dosing, administration, side effects)	☐ Yes	
Identification and management of high and low blood sugar	☐ Yes	
Nutrition (macronutrients, counting carbs, caloric and hydration needs)	☐ Yes	
Weight loss	☐ Yes	
Meal planning	☐ Yes	
Grocery shopping lists and education	☐ Yes	
Fitness recommendations and implementation	☐ Yes	
High blood pressure (medication adherence, diet, exercise recommendations and goal setting)	☐ Yes	
High cholesterol/heart disease (medication adherence, diet, exercise recommendations and goal setting)	☐ Yes	
Other:	☐ Yes	

The following MUST be signed by the referring Physician, NP, PA:

Health Provider Name (Print): _____

Health Provider Signature: _____ Date: _____