Culinary Health Fund™

INITIAL RESULTS FROM REFERRED PROVIDER

Date: _____

Weight: _____ BP: _____

BMI: _____ Waist Circum: _____

Cholesterol: _____ HDL: _____

TC/HDL Ratio: _____

Glucose (if applicable): _____

(results within past 6 months acceptable)

Referring Physician: _____ Phone: _____ Fax: _____

Office Address: _____ HRA Date Completed _____

Culinary ID# _____

Patient First Name: _____ Last Name: _____

Patient Date of Birth: _____ Sex: ☐ M ☐ F

Date of Visit	Weight	BMI	Waist Circum.	BP
Next Appt: ____/____/____	Notes:			
Next Appt: ____/____/____	Notes:			
Next Appt: ____/____/____	Notes:			
Next Appt: ____/____/____	Notes:			
Next Appt: ____/____/____	Notes:			

Please fax to the Culinary Health Fund Advocacy Department at (702) 691-5620

Revised 09/14

Culinary Health Fund™

Patient First Name: _____ Last Name: _____

Date of Visit	Weight	BMI	Waist Circum.	BP
Next Appt: ____/_____/____	Notes:			
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