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: _____

Health Risk Assessment / Date Completed: _____

Patient First Name: _____ Last Name: _____

Date of Birth: _____ Sex: _____

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 Wellness Department at (702) 691-5620

Patient First Name: _____ Last Name: _____

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

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