



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:			

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:			

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