Letter of Medical Necessity
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This letter serves as a prescription and letter of medical necessity for the patient referenced below currently being treated for obesity or overweight with one or more health consequences.

To be filled out by patient:

Patient's Name:	
Sex:	
Date of Birth:	
Address:	
Phone:	
Social Security Number:	
Physician's Name:	
Physician's Phone:	

To be filled out by physician regarding patient listed above:

Date:	
Height:	
Weight:	
BMI:	
BMI Weight Class	Normal Overweight Obese Extremely Obese
I refer this patient because of diagnosis of:	___ Morbid Obesity ___ Obesity ___ Hypercholesterolemia ___ Type 2 Diabetes ___ Sleep Apnea ___ Impaired Glucose Tolerance ___ Mixed Hyperlipidemia ___ Hypertension ___ Other (list)

Physician Comments:

Physician Signature: ____

Patients should keep this letter for their records.