NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

UMR
A UnitedHealthcare Company

Obesity Care Management Initial Evaluation Form

Personal information

Date of initial appointment _____ _____ _____ Health care provider name _____
MM DD YYYY

Member name _____ PEBP ID _____

Patient DOB _____ _____ _____ Current weight _____ Height _____ BMI _____
MM DD YYYY

Diagnosis/Co-morbidities _____

_____ Waist circumference _____

Lab work completed at initial visit

Test	Value	Date of Test
Blood pressure		MM DD YYYY
Cholesterol HDL		MM DD YYYY
Cholesterol LDL		MM DD YYYY
Blood glucose		MM DD YYYY
		MM DD YYYY
		MM DD YYYY
		MM DD YYYY

1. Will meal replacement be part of therapy? ◯ Yes ◯ No ◯ NA
2. Will prescription medication be part of therapy? ◯ Yes ◯ No ◯ NA
3. Are you recommending this patient to join your obesity care management program? ◯ Yes ◯ No ◯ NA

I, the undersigned, hereby certify that I am the named member's health care provider and I certify that I have examined the named member sufficiently to answer the above questions. Further, I certify that the above answers are true and accurate statements regarding the named member's wellness, weight and activities.

_____ Health care provider signature