



The Crawford Clinic

1900 Leighton Avenue Suite 101 Anniston, Alabama 36207
Phone: 256-240-7272 Fax: 256-240-7242

Medical Weight Loss Progress Note

Please give the following 6 medical progress notes to your primary care doctor. One of these sheets must be filled out by your doctor **each month for six consecutive months**. When all six of these sheets are completed, please return them to the office. If you elect to return these sheets as they are completed each month, make sure that your doctor has a copy for his/her records. Upon completion, we will submit this documentation to your insurance carrier to obtain prior authorization for your surgery. If these sheets are not completely filled out for 6 consecutive months, your surgery will be denied by your insurance carrier.

If you or your doctor have any questions about completing the progress sheet, please do not hesitate to contact the office. If you have any questions about what requirements are needed by your insurance carrier, please contact your medical insurance company by calling the number on the back of your insurance card.



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Medical Weight Loss Progress Note

Patient Name: _____ Date: _____

Current Weight: _____ Blood Pressure: _____ BMI: _____

Diagnoses: _____

Weight Loss Medications: _____

Diet Plan:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Nutrisystem | <input type="checkbox"/> Weight Watchers | <input type="checkbox"/> Jenny Craig |
| <input type="checkbox"/> L A Weight Loss | <input type="checkbox"/> Eat Right | <input type="checkbox"/> South Beach |
| <input type="checkbox"/> Other: _____ | | |

Is the patient compliant with the above diet plan: yes no

Daily Calorie Intake: _____

Physical Activity/Exercise Plan (times per week):

Aerobics: _____ Exercise Videos: _____

Gym Membership: _____ In-home Gym Machine: _____

Walking/Running: _____ Weight Training: _____

Other Activities longer than 30 minutes: _____

Inability to perform exercise because: _____

Recommended Exercise Modification: _____

Behavior Modification:

- | | |
|--|-------------|
| <input type="checkbox"/> Dietician Consult | Date: _____ |
| <input type="checkbox"/> Group Counseling | Date: _____ |
| <input type="checkbox"/> Individual Counseling | Date: _____ |

Recommend Behavior Modifications Changes: _____

General Comments: _____

Provider Signature: _____ **Date:** _____



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