

● Fax To: 1-877-735-0289

Learn more at [lifestylerrx.com/refer](http://lifestylerrx.com/refer)

PRIMARY REASON FOR REFERRAL		
Better Health for Type 2 Diabetes	Better Health for Chronic Conditions	GLP-1 Companion Program
<input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Prediabetes <input type="checkbox"/> Post GDM <6 months <input type="checkbox"/> Post GDM >6 months	<input type="checkbox"/> Atherosclerosis (Includes: CAD, PVD, CVA, TIA) <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Excess Weight (BMI >30) <input type="checkbox"/> Fatty Liver <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Insulin Resistance <input type="checkbox"/> Lymphedema <input type="checkbox"/> Metabolic Syndrome <input type="checkbox"/> Mild Cognitive Impairment <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> PCOS <input type="checkbox"/> Other:	<input type="checkbox"/> GLP-1 <3 months <input type="checkbox"/> GLP-1 >3 months <input type="checkbox"/> Contemplating/preparing for a GLP-1 Prescription

MEDICATION MANAGEMENT
<p align="center"><b>GLP-1 Companion Program</b></p> <input type="checkbox"/> I will prescribe and manage GLP-1 prescriptions (default if unchecked) <input type="checkbox"/> I request that LifestyleRx prescribe/manage GLP-1 prescriptions including special authority and insurance paperwork for the duration of the patient's involvement with the program

PATIENT INFORMATION		
First Name	Last Name	Phone
PHN		Email Address (optional)
Additional Notes (optional)		Mailing Address (optional)

REFERRING PROVIDER INFORMATION		
Provider Name	Billing #	Or affix stamp/label here
Signature		
Date		