

Patient ID# _____

DRAFT - Health Improvement Prescription Form PH

Healthcare Setting Name: _____

Address: _____ City: _____ Zip: _____ County: _____

Fax: (____) ____ - _____ Phone: (____) ____ - _____

Clinician: _____

Client Name: _____ DOB: ____ / ____ / ____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (____) ____ - _____ Alternate Phone Number: (____) ____ - _____

Email Address: _____

Height: _____ Weight: _____ BMI: _____

I have insurance with (check one):

- I do not have medical insurance
- Blue Cross Blue Shield (BC/BS)
- Medica
- Blue Cross Blue Shield Federal Employee Program
- UCare
- Other: _____

(Initial) I am ready to become more physically active and request a prescription for these goals.

(Initial) I am ready to eat healthier foods and request a prescription for these goals.

(Initial) I request my contact information be given to a health improvement care coordinator so he/she may contact me.

(Initial) I agree to have my health improvement care coordinator tell my health care provider(s) whether or not I enrolled and participated in health and wellness opportunities and provide them with the results of my participation.

(Initial) I am not ready to make any lifestyle changes at this time.

Client Signature: _____ Date: ____ / ____ / ____

Physical Activity Prescription:*

_____ for _____ minutes _____ days/week. Comments: _____
(walk, bike, run, swim, etc.)

Food Prescription:*

Eat _____ vegetables per day. Comments: _____

Eat _____ fruits per day. Comments: _____

Eat _____ calories per day. Comments: _____

Use one meal replacement per day (frozen diet meal) Comments: _____

Daily Journal Prescription:*

Record food intake and physical activity daily. Comments: _____

Referrals:*

Dietician Comments: _____

Exercise physiologist/sports medicine Comments: _____

Community-based resources (CBRs) per Health Improvement Care Coordinator (HICC) Comments: _____

Follow-up:*

HICC will coordinate care and contact patient monthly x 12 months beginning _____ and provide results to clinician.

Clinician Signature: _____ Date: ____ / ____ / ____

PRESCRIPTION GOOD FOR TWELVE MONTHS

Fax to: Otter Tail County Public Health, Health Improvement Care Coordinator Fax Number 218-998-8352

*<http://cme.medscape.com/viewarticle/712986>. "The Obesity Epidemic! Exploring Emerging Strategies for Weight Control and Risk Reduction" Providing Obesity Care in the Office; Slides 44-65

Health Improvement Prescription Documentation Form PH

Client Name: _____ DOB: ____ / ____ / ____

Height: _____ Initial Weight: _____ Initial BMI: _____

Prescribing Clinician: _____ Healthcare Setting: _____ Fax #: _____

APPOINTMENT DATE AND TIME:	MONTH											
	One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
COMPLETED AS PRESCRIBED:												
Dietician												
Exercise physiology												
Eating												
Physical activity												
Journaling												
Daily Calories												
Medication												
Community-Based Resources (CBRs)												
List CBRs utilized:												
Other												
OTHER INFORMATION:												
Weight												
BMI												
Educational resources provided (List source)												
Contact attempt #1												
Contact attempt #2												
Contact attempt #3												
No contact made after three attempts												
Subsequent month's appointment date												
Care Coordinator Initials												

After six months, fax document to prescribing clinician. After twelve months, fax completed document to prescribing clinician.