

Greetings!

Thank you for your interest in the Comprehensive Weight Management Program. We commend you for taking an active role on the improvement of your health! You are about to embark on one of the most positive journeys of your life, not to mention an incredible learning experience.

Please complete the enclosed questionnaires in addition to keeping a 3-7 day food and exercise log. In order for us to properly assess your specific needs and desires, it is important to be completely honest when completing the questionnaires. If you have trouble answering or are confused by any questions, please indicate so and answer the question to the best of your ability.

You will be scheduled for initial evaluation appointments with a Registered Dietician, Behavioral Health Specialist and an Exercise Specialist upon receipt of this completed packet, your physician's referral to the program, and a pre-authorization letter from your insurance company (for Priority Health Insurance only). Enclosed is a self-addressed envelope in which to return the enclosed forms. If you printed this packet from the internet, our mailing address is:

Healthy Weight Center
Munson Medical Center
1105 Sixth Street
Traverse City, MI 49684

Please note that we must receive these questionnaires prior to the scheduling of any appointments.

We do require an initial payment equivalent to half of your total estimated out-of-pocket cost at the time you are accepted into the program. You will then be asked to make payments each month so that the remainder of your account balance is paid in full by the time you graduate from the program. Munson employees may pay via payroll deduction.

Should you need to cancel or reschedule any appointment, 24-hours notice is required.

If you have any questions or concerns regarding the program, please feel free to call. We look forward to working with you.

Sarah Wetmore, M.A., CES
Coordinator
Healthy Weight Center
(231) 935-8533 (phone)
(231) 935-8609 (fax)

MUNSON MEDICAL CENTER

Healthy Weight Center

Registration Form

Patient Initials: _____

In order for us to process your registration form quickly and accurately, please print legibly and be sure to complete the entire form. If you have questions please ask for assistance.

(circle one)

Mr. Ms. Mrs. Dr. First Name: _____ MI: ____ Last Name: _____

(circle one)

Male | Female DOB: ____/____/____ E-Mail Address: _____

Address (include apartment or unit #): _____

City: _____ State (Province): _____

Zip (Postal Code): _____ Country: _____

Home Phone (include area code): _____ Other Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Physician: _____ Physician Phone: _____

For which Healthy Weight Center program are you registering? (please check one):

- Working Off Weight (W.O.W.) – 4 month program
- Comprehensive Weight Management – 6 month program

*In order to have access to the web site and program support features you must select a unique username and password, as well as a reminder question and answer in case you lose your password. Your **Username** can contain letters and numbers only (no special characters) and your **Password** should not be something easily guessed (but something easily remembered).*

NOTE – To use betterMD.net, please disable any pop-up blockers and change your email/spam filter settings to accept important email from betterMD.net and MMHWC staff messages. Contact us if you need help with this.

Username: _____ Password: _____

Choose one of the following **Reminder Questions** by placing a checkmark in the appropriate box:

- What is your mother's maiden name?
- What was the name of your first pet?
- Whom do you most admire?
- What elementary school did you attend?

Record your answer here: _____

*In accordance with the **NOTICE OF PRIVACY PRACTICES** that you previously read and signed at Munson Medical Healthy Weight Center (MMHWC), this notice informs you that the MMHWC will share the information contained in this document and other information gathered during your participation in the Weight Management Program with the company betterMD.net, Inc. By signing below you are indicating that you previously read the above stated notice and are fully aware of, and will allow, the sharing of your weight management related information with betterMD.net, Inc.*

Signature: _____ Date: _____

MUNSON MEDICAL CENTER

Healthy Weight Center

Enrollment Form

Patient Initials: _____

In order for us to process your enrollment form quickly and accurately, please print legibly and be sure to complete the entire form prior to the orientation meeting. If you are unsure of what to do please ask for assistance from a staff member at the orientation.

First Name: _____ Last Name: _____ DOB: ___/___/___

What was your weight at age 18? _____ Highest adult weight? _____ Lowest adult weight? _____

If you could weigh whatever you wanted, what would your "dream weight" be? _____

At what weight do you feel you would be happy? _____ What weight would be "acceptable" to you? _____

At what weight (less than your current weight) would you still be disappointed? _____

What weight do you have in mind to achieve as your "goal weight" through this program? _____

Please indicate which weight loss medications you have used in the past (check all that apply):

- | | | |
|-----------------------------------------------|----------------------------------------------|-------------------------------|
| <input type="checkbox"/> Phentermine | <input type="checkbox"/> Meridia® | <input type="checkbox"/> None |
| <input type="checkbox"/> Fenfluramine | <input type="checkbox"/> Xenical® | |
| <input type="checkbox"/> Dexfenfluramine | <input type="checkbox"/> Wellbutrin | |
| <input type="checkbox"/> Phen/Fen combination | <input type="checkbox"/> Other (list): _____ | |

Are you pregnant? Yes No NA Are you planning a pregnancy in the near future? Yes No NA

Are you currently breast feeding (lactating)? Yes No NA

Indicate which of the following conditions you have suffered or currently suffer from (choose all that apply):

- | | | |
|----------------------------------------------------|----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> GERD (acid reflux) |
| <input type="checkbox"/> Heart Valvular Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Type 1 Diabetes | <input type="checkbox"/> Other (list types below) |
| <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Type 2 Diabetes | <input type="checkbox"/> None |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease | |
| <input type="checkbox"/> NASH (fatty liver) | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Liver Disease (severe) | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Cancer (list types below) | <input type="checkbox"/> Gout | |

Other diseases or illnesses: _____

Types of cancer: _____

Smoking? (choose one):

Never smoked Quit smoking Less than pack/day Up to 2 packs/day More than 2 packs/day

If you smoke or used to smoke, How long? _____ yrs. If you quit smoking, when? (date) _____

Do you use alcohol? (choose one):

Never Quit drinking Less than 3 drinks/week Up to 14 drinks/week More than 14 drinks/week

MUNSON MEDICAL CENTER

Healthy Weight Center

Enrollment Form

Patient Initials: _____

Has any member of your immediate family (parents, brothers, sisters) ever had: (choose all that apply):

- | | | |
|------------------------------------------------------|----------------------------------------------|-------------------------------|
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> None |
| <input type="checkbox"/> Diabetes (type 1 or type 2) | <input type="checkbox"/> Colon Cancer | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Lung Cancer | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ovarian Cancer | |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Prostate Cancer | |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other Cancer | |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Alcoholism | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Other (list): _____ | |

Indicate what types of medication you are currently taking (prescription and over the counter - choose all that apply):

- | | | |
|--------------------------------------------------|---------------------------------------------|-------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> for Depression | <input type="checkbox"/> None |
| <input type="checkbox"/> for Weight Loss | <input type="checkbox"/> for Anxiety | |
| <input type="checkbox"/> for High Blood Pressure | <input type="checkbox"/> for Sleep | |
| <input type="checkbox"/> for Heart Disease | <input type="checkbox"/> for Hypothyroidism | |
| <input type="checkbox"/> for Birth Control | <input type="checkbox"/> for Gout | |
| <input type="checkbox"/> for Hormone Replacement | <input type="checkbox"/> for Allergies | |
| <input type="checkbox"/> for Diabetes | <input type="checkbox"/> OTHER | |

List ALL medication you are currently taking in the box below (prescription and over the counter, including vitamins – include the name of the medication, dosage, and frequency for each medicine): I am not taking any prescription medications

List any medication allergies: _____ None

List any food allergies: _____ None

List any hospitalizations for surgery, major illness or injury that required an overnight stay (include date):

_____ None

MUNSON MEDICAL CENTER

Healthy Weight Center

Enrollment Form

Patient Initials: _____

Indicate what symptoms you are currently experiencing (choose all that apply):

- | | |
|----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Vaginal bleeding |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Unusual skin lumps |
| <input type="checkbox"/> Swallowing problems | <input type="checkbox"/> Breast lumps or changes |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain in hands |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pain in feet |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Pain in hips |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pain in knees |
| <input type="checkbox"/> Indigestion/Nausea | <input type="checkbox"/> Pain in back |
| <input type="checkbox"/> Lactose intolerance | <input type="checkbox"/> Pain in neck |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Pain in shoulder |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pain in elbow |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Trouble walking |
| <input type="checkbox"/> None | <input type="checkbox"/> Other (list) _____ |

Do you have a history of: (choose all that apply)

- | | | | |
|---------------------|--------------------------------|-------------------------------|----------------------------------|
| Anorexia | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| Bulimia | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| Binge eating | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| Incest/sexual abuse | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |

Once you have completed page two through page five of this enrollment form, be sure to add your initials to the top left corner of all four pages. Page six and seven will be completed by a staff member at the conclusion of your Orientation meeting.

Important Note – You must hand in your registration and enrollment forms, as well as your physician's authorization before your program start appointment will be scheduled. If you have any questions, please contact one of the Munson Medical Healthy Weight Center staff members.

Hint – To use betterMD.net, please disable any pop-up blockers and change your email/spam filter settings to accept important email from betterMD.net and MMHWC staff messages. Contact us if you need help with this.

In accordance with the NOTICE OF PRIVACY PRACTICES that you previously read and signed at Munson Medical Healthy Weight Center (MMHWC), this notice informs you that the MMHWC will share the information contained in this document and other information gathered during your participation in the Weight Management Program with the company betterMD.net, Inc. By signing below you are indicating that you previously read the above stated notice and are fully aware of, and will allow, the sharing of your weight management related information with betterMD.net, Inc.

Signature: _____ Date: _____

MUNSON MEDICAL CENTER
Healthy Weight Center

Enrollment Form

Patient Initials: _____

STAFF USE ONLY

Physical Exam Worksheet

Patient Name of Record: _____

EMR Identification Number: _____

Height: _____ inches Weight: _____ lbs. Waist Circumference: _____ inches

Hip Circumference: _____ inches BP: _____/_____ Heart Rate: _____ bpm.

Lab values: Labs recorded below (drawn on: ___/___/___) Labs requested Labs not required

Tot Cholesterol: _____ LDL: _____ HDL: _____ Triglycerides: _____

Hgb A1c: _____ Fasting Glucose: _____ Thyroid (TSH) : _____

For which Healthy Weight Center program is this patient enrolling? (please check one):

- Working Off Weight (W.O.W.) – 4 month program
- Comprehensive Weight Management – 6 month program

Visit setting: Individual session Group session

These GOAL Weight entries require body mass measurements - DO NOT record weight LOSS goals

Initial weight goal: I want to weigh _____ lbs. in 4 weeks

Long-term weight goal: I want to weigh _____ lbs. eventually

Motivations to lose weight (choose two)

- improve health improve appearance feel better live longer
- wishes of family members wishes of friends or others

OTHER (not listed): _____

Barriers to success (choose two)

- exercise lack of motivation poor food preparation poor food choices
- inability to control eating/portion sizes lack of time money
- lack of support from family or others

OTHER (not listed): _____

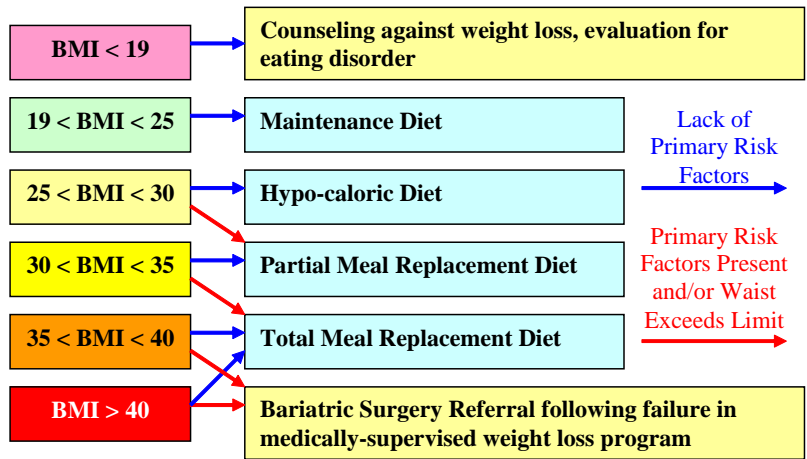
MUNSON MEDICAL CENTER

Healthy Weight Center

Enrollment Form

Patient Initials: _____

Treatment Plan Protocol



Treatment Plan (choose one):

- Total Meal Replacement** (full supplements – estimated rate of loss 3-5 lbs/wk)
- Partial Meal Replacement** (partial supplements with food plan – estimated rate of loss 2-3 lbs/wk)
- Hypo-caloric** (no supplements with 700 cal deficit whole food plan – estimated rate of loss 1-2 lbs/wk)

If the Treatment plan is not selected according to this protocol, please indicate the reason for your choice:

- PCP Preference
 Patient Preference
 Comorbidity
 Financial Considerations
 Supplement Intolerance
 Other: _____

Physician consent received? Yes No n/a (non-supplemented plan)

Has a start date appointment been scheduled? Yes No Date of the appointment: ____/____/____

Other comments:

Staff member (signature): _____

Staff member (please print): _____ Date of service: ____/____/____

MUNSON MEDICAL CENTER

Comprehensive Weight Management Program

Meal Plan Options

All diet plans are supported by medical research as effective means for losing weight.

Meal Plan: Hypocaloric

This plan has been designed to provide optimum nutrition that will help you lose or control your weight and maintain health. Along with regular exercise and lifestyle education, this plan is designed to help you lose 1-2 pounds per week, although results may vary from person to person. This plan includes the use of whole foods that are portion based on food groups and calorie content, but can also include the use of meal replacement supplements. The calorie range for this plan is 1,200 to 1,600 calories per day. Eating from a wide variety of foods provides better overall nutrition.

Meal Plan: Partial Meal Replacement

This plan uses a structured diet of pre-packaged entrees (purchased at the grocery store), dairy products, fruits and vegetables, plus approximately 4 packets of meal replacement supplements (purchased from our vendor) per day. This plan along with regular exercise and lifestyle education is designed to help you lose 2-3 pounds per week. The calorie range for this is 1,000-1,200 calories per day. This plan may be recommended for those who are 25 to 50 pounds overweight.

There is an additional cost of approximately \$41-62 per week for supplements.

Meal Plan: Total Meal Replacement

This plan exclusively uses protein based meal replacement supplements. The typical plan equals 600-800 calories per day. For safe progress, patients on this plan may be required to make and attend follow-up visits at the Healthy Weight Center Clinic with our program Medical Director, or with your own Primary Care Provider. These appointments are not included in the program fee. This plan along with regular exercise and lifestyle education is designed to help you lose 3-5 pounds per week, and is best for those who are 25 – 100+ pounds overweight.

There is an additional cost of approximately \$65-88 per week for supplements.

MUNSON MEDICAL CENTER

Comprehensive Weight Management Program

Scheduling Guide

Intake Assessment *Location: Munson Community Health Center, 550 Munson Avenue*

A 90-minute appointment to determine if you are ready for the program.

First Visit

Each part of your "First Visit" is 50 to 60 minutes in duration.

- Registered Dietitian: *Location: Munson Community Health Center, 550 Munson Avenue*
- Social Worker *Location: Munson Community Health Center, 550 Munson Avenue*
- Exercise Specialist *Location: Munson Community Health Center, 550 Munson Avenue*

Registered Dietitian *Location: Munson Community Health Center, 550 Munson Avenue*

Depending on need, schedule ten to sixteen to half-hour sessions based on your Registered Dietitian's recommendations. You must attend a minimum of 10 sessions for successful completion of this portion.

Behavioral Health *Location: Munson Community Health Center, 550 Munson Avenue*

At your first appointment, the behavioral health specialist will determine how many sessions are necessary. Five to eight sessions are available to you throughout your time in the program. You must attend a minimum of 5 sessions for successful completion of this portion.

Exercise Specialist *Location: Munson Community Health Center, 550 Munson Avenue*

Seven (7) individual sessions required. Your first session will be one hour in duration; the remaining six will be a half-hour in duration. You must plan for a half-hour of cardio (on your own) **before** your individual sessions with the exercise specialist. You must attend a minimum of 6 sessions for successful completion of this portion.

Supervised Exercise *Location: Munson Community Health Center, 550 Munson Avenue*

One session required each week throughout the duration of the program (unless you choose to participate in the circuit training class). An exercise specialist will be available to assist you throughout your workout and will obtain your weight at the beginning of each session. You must attend a minimum of 10 sessions for successful completion of this portion.

Group Education *Location: Munson Community Health Center, 550 Munson Avenue*

Schedule a total of eight classes in the last eight weeks of the program (Class is held on Thursdays at 5:30 p.m. in Conference Room E) Speakers for the classes will rotate between the Behavioral Health Specialist and the Registered Dietitian. See class schedule for topics. You must attend a minimum of 6 classes for successful completion of this portion.

Circuit Training *Location: Munson Community Health Center, 550 Munson Avenue*

This class follows the Group Education class on Thursday evenings. Circuit training begins at 6:30 p.m. and is located in the Physical Therapy Gym. You must attend a minimum of 6 sessions for successful completion of this portion.

We do have a 24-hour cancellation policy. If you need to make any changes in your schedule, please do so at least 24 hours in advance by calling (231) 935-8533. Cancellations with less than 24 hours advanced notice or no-shows cannot be made up. A total of 3 missed appointments may lead to dismissal from the program.



MUNSON HEALTHCARE

HEALTHY WEIGHT CENTER
Phone: (231) 935-8533
Fax: (231) 935-8609

Comprehensive Weight Management Program Prior Authorization and Referral Form

Fax form to *both facilities*:

1. **Comprehensive Weight Management Program**
FAX: (231) 935-8609 PHONE: (231) 935-8533
2. **Priority Health-Traverse City Office**
FAX: (231) 932-9505 PHONE: (231) 932-7955

Priority Member ID #: _____

Patient Name: _____ D.O.B.: ____/____/____
(Last) (First)

Address: _____
(Street) (City) (Zip)

Phone: Home (____) _____ Other: (____) _____

- Initial Request
- Retreatment Request

Start Date of Last Program: _____

CLINICAL CONDITION

Date weight and height measured: _____

Current Weight: _____ Current Height: _____ BMI: _____

CHECK CRITERIA THAT APPLIES:

- BMI greater than or equal to 35 and two obesity-related co-morbidities *OR*
- BMI greater than or equal to 40 and one obesity-related co-morbidities *OR*
- BMI greater than or equal to 45 (co-morbidities not needed)

CO-MORBIDITIES: CHECK ALL THAT APPLY AND LIST MEDICATIONS FOR EACH AS APPLICABLE

- Diabetes (HbA1C greater than 8.0) HbA1C _____
- Hypertension requiring medication _____
- GERD (persistent symptoms despite daily medications) _____
- Symptomatic Sleep Apnea A/H Index = _____
- Significant cardiac disease (Documented ASHD, LVH or RVH)
Diagnosis: _____
- Hyperlipidemia (greater than 30mg/dl above goal) requiring medication (list all medications below)
HDL: _____ LDL: _____ TG: _____ Total: _____
1. _____ 2. _____ 3. _____
- Degenerative joint disease markedly limiting daily activities
- Non-alcoholic steatohepatitis (NASH)
- Depression requiring medication and psychological counseling
- No co-morbidities present

CONTRAINDICATIONS TO PHYSICAL ACTIVITY

- Unrestricted
- Progressive exercise (no restrictions)

Primary Care Physician: _____
PCP Phone: (231) _____

Signature: _____
PCP Fax: (231) _____