RadianceMD
EMBRACE YOUR RADIANCE, TRANSFORM YOUR LIFE

RadianceMD Referral Form

A 3300 NW 185th Ave, #384, Portland, OR 97229
P (971) 432 - 6232 F 866-422-1929
E transform@radiancemd.org

Patient Information

Patient Name: _____ Date of Birth: _____

Email: _____ Cell Phone: _____

Reason for Consult: (check all that apply)

- ☐ Cardiometabolic Consult
- ☐ Personal Training/Health Coach
- ☐ Botox
- ☐ Weight Loss
- ☐ Body Composition Analysis
- ☐ Group Cooking/Exercise Classes

Diagnoses: (check all that apply)

- ☐ Overweight: BMI between 25 and 29.9
- ☐ Obesity: BMI between 30-34.9
- ☐ Obesity: BMI between 35 and 39.9
- ☐ Obesity: BMI > 40
- ☐ Obesity Hypoventilation Syndrome
- ☐ Depression
- ☐ Cancer
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Coronary Artery Disease
- ☐ Obstructive Sleep Apnea
- ☐ Nonalcoholic Fatty Liver Disease
- ☐ Type II Diabetes
- ☐ PTSD

Other: _____

Physician Information:

Referring Physician: _____ Primary Care Physician: _____

Referring Physician Fax: _____ Primary Care Physician Fax: _____

Referring Physician Phone: _____ Primary Care Physician Phone: _____

Referring Physician Address: _____ Primary Care Physician Address: _____

_____ _____

Referring Physician Signature *Date*

Please Fax **(866-422-1929)** a copy of latest chart note and medication list with this referral