UF Health Bariatric Surgery Program

Medically Supervised Diet and Exercise Program

Patient Name: _____ MRN#: _____ Date of Birth: _____

Date of Visit: _____ Visit Number: _____

Instructions: Please complete this form in its entirety –one for each month. The patient must be on a supervised weight loss diet program for consecutive months (3 or 6) per insurance criteria. The Patient will be informed of how many months are required per their insurance criteria. Medical Supervised weight loss/failed weight loss attempts is not a monthly weigh in but a diet/exercise program.

Height: _____ Weight:_____ HR: _____ B/P: _____

Treatment recommendation: Please indicate what type of diet plan you have recommended.

Calorie level diet: _____ total calories per day or restriction of _____calories a day.

Macronutrient diet: Low carbohydrate Low fat high protein

Structure programs: Weight Watchers Metabolic Medical Center/ Physician plan

Meal replacement: Nutrisystem diet Optifast/ Medifast Slim Fast Jenny Craig

Other: _____

Medication: _____ _____ _____ _____

Physical Activity:

Walking	Yoga/Pilates	Swimming
Aerobics	Curves	Gym/Club membership
Water aerobics	Physical Therapy	
Other:		

Pt is unable to exercise due to: _____

Frequency: 0-2 times per week 3-4 times per week 5-7 times per week

Response to prescribed regimen in past month: Lost: _____ pounds Gained _____ pounds

Patient is compliant with diet and/or exercise program: Yes No

Comment: _____

_____

Physician Signature