



PHYSICIAN APPROVAL FORM

I understand that my patient _____, is currently enrolled in **SHAPEDOWN**, a weight management program, for children and adolescents.

I am aware that **SHAPEDOWN** encourages a wide range of behavioral and affective changes and recommends a low caloric density (low-fat, low-refined carbohydrate) diet of no fewer than 1,200 to 1,500 kcal per day. Thirty to sixty minutes of daily exercise are recommended.

1. This patient has had a recent physical exam, the results of which are attached, along with any weight chart history available.
2. The following **12-hour fasting** lab tests have been done and the results are attached (for children over age 5):

____ CBC	____ LIPID PROFILE
____ TSH	____ LFT's
____ GLUCOSE	____ INSULIN

3. Tanner Stage _____
4. This patient has medical problems or takes medications that may affect his or her participation in the intervention: ____yes ____no If yes, please describe: _____

5. This patient has emotional difficulties or family problems that may affect his or her participation in the intervention: ____yes ____no If yes, please describe: _____

Additional comments: _____

I approve of my patient's participation in the **SHAPEDOWN** program at this time.

(physician's signature)

(date)

(print physician's name)

(address)

(phone)

(fax)