Obesity Care Management Monthly Engagement Form

Member measurements

*Required fields

Member name* _____ PEBP ID* _____

Initial weight* _____ Target weight goal* _____ Cycle weight less goal* (Enter weight) _____ Appointments completed* (Enter count) _____ Months into program* _____

Member and appointment information

*Required fields

Waist circumference* _____

Date of **this** appointment* _____/_____/_____ (MM / DD / YYYY) Date of **next** appointment* _____/_____/_____ (MM / DD / YYYY) BMI* _____

Patient's weight on appointment day* _____ Consultant/Coach* _____ Blood pressure* _____

Location of appointment _____ What type of visit was this?* _____ Program completion date* _____/_____/_____ (MM / DD / YYYY)

Client compliance

1. Is the patient compliant with nutritional instructions? Yes No NA
2. Was the patient's goal weight discussed? Yes No NA
3. Were participation expectations discussed? Yes No NA
4. Are there any barriers to successful outcomes? Yes No NA

   If yes, please explain: _____
   Attach additional information to this document if necessary.

5. Is the patient compliant with physical activity instructions? Yes No NA

   Describe patient's physical activity on a weekly basis: _____
   Attach additional information to this document if necessary.

6. Was patient compliant with all appointments expected for the month? Yes No NA

   If no, please explain: _____
   Attach additional information to this document if necessary.

7. Your perceived level of patient's desire to achieve their goals? *Attach additional information to this document if necessary.*

   _____

8. If yes, did the patient agree to comply? Yes No NA

I, the undersigned, hereby certify that I am the named member's health care provider and I certify that I have examined the named member sufficiently to answer the above questions. Further, I certify that the above answers are true and accurate statements regarding the named member's wellness, weight and activities.

_____ Health care Provider Signature