GP / Specialist Approval Form

[attach program brochure]

Applicant Details [This section must be completed and signed by the applicant]			
Name			
Date of Birth			
Health Fund Membership Number		Health Fund Name	
Phone Number			
Email Address			
Signature		Date	

GP / Specialist Approval [This section must be completed and signed by a GP or Specialist]			
Applicant's current weight (kg)		Height (cm)	
Eligibility Criteria: [applicant must meet <u>either</u> criteria A or B below, please tick].			
Criteria A ☐ 1. BMI ≥ 28 kg/m2; and, 2. Health risk factor/s that may be alleviated by reduction in weight; or, 3. Diagnosed chronic health condition of which outcomes may be improved with weight reduction. Please detail the relevant health condition/s: _____ _____ _____ _____		**Criteria B** ☐ 1. BMI ≥ 30 kg/m2	
☐ **In my opinion it is medically appropriate and, giving due consideration to any contraindications, safe for this patient to actively lose weight.** [Please tick if appropriate].			
		Doctor signature	
Doctor name, address, phone, provider number [please stamp or print].		Date	