BRONSON

Affix Patient Label

Bronson Methodist Hospital
601 John Street Box 27
Kalamazoo, MI 49007
Phone: (269) 341-6860
Fax: (269) 341-7187

Encounter Number:_____ Date of Service:_____

PATIENT DATA

Name:_____ Sex: ☐ Male ☐ Female
Date of Birth:_____ Age:_____
Address:_____
_____
Home phone:_____
Work phone:_____
Cell phone:_____
Parent / Legal guardian:_____
Insurance:_____

Referred by:

☐ Physician
☐ Self
☐ Wellness
☐ Follow up

Comments:_____
_____
_____

Date:_____ Height:_____inches_____cm Weight:_____lbs_____kg BMI:_____ Weight change:_____

If referring for gestational diabetes:
Expected date of confinement:_____ Pregravid weight:_____ ☐ lbs ☐ kg Current weight:_____ ☐ lbs ☐ kg
Gestational age:_____weeks

For pertinent lab work:
☐ Lab results are available through the Bronson lab system
☐ Lab results NOT available through the Bronson lab system - please provide copy of official lab results

ORDER

Physician's name:_____
RN/Referral Coordinator:_____
Phone:_____
Dr. Address:_____

Patient diagnosis:_____
Diagnosis code:_____
Medicare insurance ☐ Yes ☐ No

Physician/Provider Signature:_____ Date:_____ Time:_____

FOR DIETITIAN'S USE ONLY
Appointment Information:
Day:_____ Date:_____ Time:_____ ☐ a.m. ☐ p.m Registered Dietitian:_____
Follow Day:_____ Date:_____ Time:_____ ☐ a.m. ☐ p.m Registered Dietitian:_____

Food Record ☐ Yes ☐ No sent date:_____/☐ received
Provider note:_____ Billable time:_____ Charged:_____

Notify Dr. of scheduled appointment ☐ Yes ☐ No

Left message:_____ Left message:_____
Will call us:_____