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:_____

Referred for:_____

Parent / Legal guardian:_____

Address:_____

_____

Comments:_____

Referred by:
☐ Physician
☐ Self
☐ Wellness
☐ Follow up

Home phone:_____
Work phone:_____
Cell phone:_____

Date:_____ Length/Height:_____inches_____cm Weight:_____lbs_____oz_____kg
FOC (under 3 years): _____inches_____cm

If referring for Failure to Thrive OR Obesity, provide measurements from 2 prior visits:

Date:_____ Length/Height:_____inches_____cm Weight:_____lbs_____oz_____kg
FOC (under 3 years): _____inches_____cm

Date:_____ Length/Height:_____inches_____cm Weight:_____lbs_____oz_____kg
FOC (under 3 years): _____inches_____cm

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:_____
Insurance:_____

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:_____ DOS:_____
Provider note:_____ Billable time:_____ Charged:_____ DOS:_____

Notify Dr. of scheduled appointment ☐ Yes ☐ No

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