Physician Referral Form

☐ **I am referring my patient to the following WW® program**

(Formerly Weight Watchers)

☐ **WW Digital + Unlimited Workshop Program for Members Age 18+**

- Up to 10 weeks of WW digital and web-based classes and workshops
- Up to 14 weeks of access to online tools

WW Digital + Unlimited Workshops for Carolina Complete Health (CCH) members age 18 years or older with a BMI equal to or greater than 25. and are referred by a CCH Care Manager. This holistic program includes:

- **Around-the-clock live coaching via the app and website.**
- **On-demand audio and video workouts, meditations, and more.**
- **Supportive Workshops.** (No in-person option included)

☐ **Kurbo by WW Program for Members Age 13-17**

3-month package of Kurbo by WW for Carolina Complete Health members age 13-17 years of age with a BMI ranked in 85% percentile and are referred by a CCH Care Manager. This program helps kids and teens build healthier habits.

- **They get to pick what they eat.** All foods are allowed. A simple traffic light system labels foods as green, yellow, or red to guide kids and teens toward healthier options.
- **They use their phone to track.** A fun mobile app keeps them on track. Videos and games encourage physical activity, and in-app medications help kids and teens manage stress.
- **They connect with a personal coach.** Regular check-ins with a Kurbo-certified coach deliver all the tips and encouragement kids need to reach their goals.

Form completion required to determine eligibility.

An office visit required only if member has not been seen by PCP in the past 12 months.

Both sides of this form must be completed

FAX both sides of completed form to:

1-844-915-0459

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MEDICAL PROVIDER INFORMATION

Medical Provider Name: _____

Practice Name: _____

Office Phone: _____ Office Fax: _____

Medical Provider Certification
This patient is:

☐ Not cleared to exercise at this time ☐ Cleared to exercise with no restrictions

☐ Cleared to exercise with the following restrictions. Please list restrictions below:

_____
_____
_____
_____

☐ I have obtained participant authorization to release information to WW and to include the patient's most recent medical records.

Medical Provider Signature _____ **Date** _____

PARTICIPANT INFORMATION

Participant Name: _____

Address: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Insurance Carrier: _____

Birthdate: _____ Height: _____ Weight: _____Gender: _____

Both sides of this form must be completed.