PEDIATRIC MEDICAL CLEARANCE FORM
CCTT/RTEAM™

4986 Adams Rd, Suite E
Rochester Hills, MI 48306
Tel: 248-475-4701 · Fax: 248-475-5777

PATIENT INFORMATION

Patient First Name: _____ Last Name: _____

Gender: ☐ Female ☐ Male D.O.B.: _____ Email: _____

Guarantor Name: _____ D.O.B.: _____

Address: _____ City: _____ Zip Code: _____

Phone Number: _____ Relationship to the patient: _____

Health Insurance: _____ Contract No. or Policy No.: _____

THE FOLLOWING INFORMATION IS REQUIRED FOR PARTICIPATION IN THE PROGRAM:

Physical Exam: (Information must have been obtained within the last 12 months)

Ht: _____Wt: _____ B/P: _____/_____
BMI: _____ BMI%Age/Sex: _____
Waist Circumference: _____
Skin Markings: _____
Other Finding:_____

Has the prospective participant been evaluated by any of the following for weight related issues? If yes, explain.

☐ Orthopedic _____
☐ Endocrinology _____
☐ Cardiology _____
☐ Gastroenterology _____
☐ Pulmonary _____
☐ Behavioral Health _____
☐ Other: _____

Please attach copy of laboratory studies within the last 12 months. Fax a copy of labs to 248-475-5777.

Required Lab Studies:	Check if Done:
Liver Function (SGOT and SGPT)	☐
Fasting Glucose	☐
Total Cholesterol	☐
LDL	☐
HDL	☐
Triglycerides	☐

Optional Lab Studies:	
Thyroid Function(Free T4, TSH)	☐
Insulin Level	☐
Hemoglobin A1C	☐
CBC	☐
Creatinine	☐
BUN	☐
Urine Protein	☐
Urine Glucose	☐

MUST CHECK BOTH BOXES TO JOIN THE PROGRAM

☐ **Participant is cleared to join in exercise program.**
☐ **May participate in group sessions (R-Team™).**

MUST CHECK APPROPRIATE DIAGNOSIS TO JOIN THE PROGRAM

☐ **V85.53 Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age**
☐ **V85.54 Body Mass Index, pediatric, greater than or equal to 95th percentile for age**
☐ **Secondary Dx/Other:**

REFERRING PHYSICIAN INFORMATION

Physician Name (Please Print):

Physician Signature: Date:

Contact Name (person that fills out the form): Telephone: