

**PRIVACY ACT STATEMENT:** This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

### COMMAND WEIGHT REFERRAL

<b>SECTION 1: UNIT</b>			
This date, I have determined _____ is _____ pounds overweight and _____ percent excess body fat or is _____ pounds under BMI minimum standard.			
Neck	(inches)	Height	(inches)
Waist	(inches)	Weight	(pounds)
Buttock (Female Only)	(inches)	Percent Body Fat	%
Name of Measuring Officer: _____		Date: _____	
<p>In accordance with Coast Guard Weight and Body Fat Standards Program Manual, M1020.8 (series), a determination is required whether it is safe for this member to lose the excess weight or body fat to comply with established standards and participate in physical activity. If under BMI minimum standard, member referred for medical assessment/monitoring (section 2 is not applicable).</p>			
Commanding Officer's Signature: _____		Date _____	

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)</i>		REGISTER NUMBER	WARD NUMBER

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

Medical Record  
**STANDARD FORM 600** (REV. 11/2010)  
 Prescribed by GSA/ICMR  
 FIRMR (41 CFR) 201-9.202-1



**SECTION 2: MEDICAL PROVIDER**

This Coast Guard member is being referred to you because s/he does not meet Coast Guard weight standards. Your responses on this form will assist the Coast Guard in developing a safe plan for the member to lose weight.

1. Is the member pregnant (for females only)? If yes, indicate approximate due date, and leave items 2-6 blank.

Yes \_\_\_\_\_ No \_\_\_\_\_

2. Are there any medical diagnoses or medications that could be contributing to the member's excess weight?

Yes \_\_\_\_\_ No \_\_\_\_\_

3. Are there any medical or physical conditions that can limit participation in physical activity?

Yes \_\_\_\_\_ No \_\_\_\_\_

4. Please list the activities the member cannot safely participate in:

5. Has the member been directed to a Regional Health Promotion Manager for nutrition counseling? If no, enter remarks.

Yes \_\_\_\_\_ No \_\_\_\_\_

6. Please indicate which components of the fitness test it is safe for the member to participate in:

a) 1.5 mile run Yes \_\_\_\_\_ No \_\_\_\_\_

b) Push-ups Yes \_\_\_\_\_ No \_\_\_\_\_

c) Curl-ups Yes \_\_\_\_\_ No \_\_\_\_\_

:

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Name & Address

