NOTIFICATION OF WEIGHT CHANGES

FAX TO: Dr. _____

FROM: _____ (Facility Name)

DATE: _____

This is to inform you that Mr./Ms. _____ a
name of resident

resident of _____ (assisted living
name of facility

facility) has experienced:

- A ***weight GAIN*** of _____ pounds in the past thirty (30) days.
- A ***weight LOSS*** of _____ pounds in the past thirty (30) days.

_____	_____
Month/Day/Year	**Preceding Month Weight**
_____	_____
Month/Day/Year	**Current Weight**

_____
Facility Representative

_____
Date

Physician Recommendations:

_____

_____

_____ _____
MD SIGNATURE **Date**

9.1.d. * West Virginia assisted living state regulations mandate that this information be sent to you for your review.