

Primary Care Physician Referral Form for Bariatric Surgery

All questions must be complete for insurance submission.

1. Patient Information.

Patient Name: _____	Date of Birth: _____
Height: _____ Last recorded weight was _____ lbs. on ____/____/____ BMI: _____	
Morbidly obese for at least 5 years: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<i>Note: Morbid obesity is defined as either having a BMI greater than or equal to 40 or having a BMI greater than or equal to 35 and an existing documented comorbid condition (diabetes, hypertension, sleep apnea, etc).</i>	
Is there an endocrinological reason for the obesity? <input type="checkbox"/> YES <input type="checkbox"/> NO	

2. Please document all professionally supervised weight loss attempts.

Program	Year	Number of months the program was followed	Supervised by Doctor (Y/N)	Total weight loss using this program
Weight Watchers				
Jenny Craig				
LA Weight Loss				
Nutri System				
Optifast				
Medifast				
Registered Dietitian/ Nutritionist				
Atkins Diet				
Calorie Controlled Diet				
South Beach Diet				
Other				

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Patient Name: _____

DOB: _____

3. Patient has the following documented co-morbidities (check all that apply):

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Coronary Disease | <input type="checkbox"/> Pulmonary Disease | _____ |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Degenerative Arthritis | _____ |

4. Patient has significant disease to any of the following (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> History of DVT/PE |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Gastrointestinal Disease |

5. Current use of tobacco/tobacco products? YES NO

If yes, list # of packs/amount per day: _____

If patient has quit, list quit date: _____

6. Use of Alcohol? YES NO

If yes, list amounts/frequency: _____

If a history of alcoholism, list date of abstinence: _____

7. Use of illicit drugs? YES NO

If yes, please list names and frequency: _____

If there is a history of drug use, list date of abstinence: _____

8. My patient is generally compliant with follow-up appointments, medications, and health care recommendations. YES NO

Please attach a list of the patient's current medication regimen.

By signing this form, I, as the patient's primary care doctor, am recommending Bariatric Surgery and am indicating that the patient is medically cleared for surgery.

Printed name of Physician

Signature of Physician

Date

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PLEASE FAX THIS COMPLETED FORM TO (585)341-0215

