

Highland Hospital
BARIATRIC SURGERY CENTER
1000 South Avenue
Rochester, NY 14620
585-341-0366

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Enter any content that you want to repeat, including other

content controls. You can also insert this control around table rows in order to repeat parts of a table.

Primary Care Physician Intake 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				
Opti fast				
Medi fast				
Registered Dietitian/ Nutritionist				
Atkins Diet				
Calorie Controlled Diet				
South Beach Diet				
Other				

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Julie Anne Leo, PA-C
Molly Adcock, NP

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

All questions must be answered for insurance submission.

PLEASE FAX THIS COMPLETED FORM TO (585) 341-8326

