Primary Care Physician (PCP) Referral Form

All Questions Must Be Answered for Insurance Submission

Today’s Date: ____________________

Patient Name: _____________________________________  Date of Birth: __________________

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).

1. **My patient has been morbidly obese for at least 5 years:**  ☐ Yes  ☐ No

2. Patient’s height is __________, last recorded weight was _____lbs. on   /   /   BMI: ________

3. Please document the professionally supervised weight loss methods that your patient has attempted. (The following are the most commonly used methods).

<table>
<thead>
<tr>
<th>Program</th>
<th>Year</th>
<th>Number of months the program was followed</th>
<th>Supervised by Doctor (Y/N)</th>
<th>Total weight loss using this method</th>
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<tbody>
<tr>
<td>Weight Watchers</td>
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<td>Jenny Craig</td>
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<td>LA Weight Loss</td>
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<td>Registered Dietitian / Nutritionist</td>
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<td>Atkins Diet</td>
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<td>Calorie Controlled Diet</td>
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<td>South Beach Diet</td>
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<td>Other</td>
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</table>

5. My patient has the following **documented co-morbidities** (check all that apply):
   ☐ Hypertension  ☐ Diabetes  ☐ Other: __________________________
   ☐ Coronary Disease  ☐ Pulmonary Disease  ☐ Degenerative Arthritis
Patient Name: ____________________________ Date of Birth: ____________

6. My patient has significant disease to any of the following (check all that apply):
   - Liver disease
   - History of DVT/PE
   - Kidney disease
   - Gastrointestinal disease (GERD)

7. Any current use of tobacco/tobacco products?  ☐ Yes  ☐ No
   If yes, please list # of packs/amount per day: ____________________
   If the patient has quit, please give date patient quit: ____________

8. Any use of alcohol?  ☐ Yes  ☐ No
   If yes, please list amounts/frequency: __________________________
   If there is a history of alcoholism, list date of abstinence: ______

9. Any use of illicit drugs?  ☐ Yes  ☐ No
   If yes, please list names and frequency: _________________________
   If there is a history of illicit drug use, list date of abstinence: _____

10. Is there an endocrinological reason for the obesity  ☐ Yes  ☐ No.

11. My patient is generally compliant with follow-up appointments, medications and healthcare recommendations.  ☐ Yes  ☐ No

Please attach a list of the patient’s current medication regime.

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

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