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Referral for: ☐ Bariatric Surgery
☐ General Surgery
☐ Post bariatric surgery follow up

Today's Date: ________________

Patients Name: ____

DOB:_________________________Age:___________________Gender_________________________

Phone Number for Scheduling:____

Current Mailing address:____

____

Current Insurance:____________________________Insurance ID/Number _______________________

Comorbidities:

☐ Morbid Obesity	☐ GERD	☐ Hypothyroidism	☐ Inguinal Hernia
☐ Diabetes	☐ Asthma	☐ Depression	☐ Umbilical Hernia
☐ Hypertension	☐ Hyperlipidemia	☐ Cholelithiasis	☐ Incisional Hernia
☐ OSA	☐ Edema	☐ Cholecystitis	☐ PCOS

Social History

Tobacco : current ☐ former ☐ packs per day:______

Alcohol: ________________________________

Recreational Drugs: ____________________

Other relevant history:

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____

Referring Provider Signature: ____

Referring Provider Name (Printed) and NPI: ____

Please send a current medications list and any weight loss visit notes that you may have.
If you are referring your patient for Bariatric Surgery evaluation they will need to complete 3-6 consecutive months of monitored weight loss. For insurance purposes it is important that the notes explicitly discuss diet and exercise.
We would appreciate your assistance in completing this.