Primary Care Physician Documentation for Bariatric Surgery Approval
BRING THIS TO YOUR PRIMARY CARE DOCTOR

Patient Name:		Date of Birth:	
I am referring this patient to you for consideration of weight loss surgery for severe obesity.			
The patient has been morbidly obese for at least five years:		**□ Yes**	**□ No**
I have followed the patient's diet/exercise for at least 6 months		**□ Yes**	**□ No**
My patient's height is:	Inches		centimeters
My patient's last recorded weight is:	pounds		kilograms
My patient's BMI is:			

My patient has the following co-morbidities:

□ Diabetes	□ Sleep apnea	□ Asthma
□ Hypertension	□ Depression	□ Pulmonary Disease
□ Arthritis	□ Degenerative Arthritis	□ GERD
□ Backache	□ Coronary Disease	
□ Other (please list):		

□ There is no significant liver, kidney, or gastrointestinal disease present.
□ There is no treatable cause for obesity such as adrenal or thyroid disorder.
□ There are no cardiac or pulmonary contraindications to bariatric surgery.
□ There is no history of alcohol or substance abuse.

***** (IF ANY BOX REMAINS UNCHECKED, PLEASE ADDRESS WHY):** _____
_____ _____
_____

□ Screening Mammogram N/A No Yes (date) _____
□ Screening Colonoscopy N/A No Yes (date) _____

TSH level (within last 6 months) _____

PLEASE ATTACH A COPY OF ALL RECENT LAB RESULTS
PLEASE ATTACH CURRENT MEDICATION LIST

The remainder of the physical examination is:
□ Unremarkable
□ Positive for: (please list) _____

By signing this form, I believe the patient is a good candidate for surgery and would benefit from significant weight loss. I would be happy to see the patient again prior to surgery for medical clearance.

Practice Name & Address_____

Phone _____ Fax _____

Print name of Physician _____

Signature _____ Date _____

Please fax completed form and requested information to (716) 565-3988

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