Northern Light Surgical Weight Loss
Referral Form

Patient Name: _____ DOB: _____ /_____ /_____

Address: _____ City/Zip:_____

Phone: (H)_____ (W) _____(Cell) _____

Primary Insurance:
Name/certificate/group#_____

Secondary Insurance:
Name/certificate/group#_____

Height: _____ Weight: _____ Body Mass Index: _____

Indications for referral:

☐ Morbid obesity (BMI ≥ 40)

☐ Obesity (BMI 35-39.9 with 1 of the following: heart disease, type 2 diabetes, HTN, obstructive sleep apnea)

Please check if patient has had prior weight loss surgery

- Prior weight loss surgery; What year_____Which procedure:_____
- *Prior antireflux surgery:*
  Operative reports or discharge summaries helpful if available

Relative contraindications to weight loss surgery:

Tobacco product use* Yes or No

Psychiatric hospitalization in the past year: Yes or No

Use of any marijuana products: Yes or No

***We can no longer accept referrals on patients who use tobacco products because of unacceptable complication rates. For those who have quit in the past 12 months, we request that your office provide negative nicotine testing to document.**

With this referral and my signature I authorize the following evaluations prior to surgeon consult and surgery:

1. Med. Nutrition Therapy 2. Psychological Evaluation 3. Physical Therapy Evaluation/Treatment
4. Split-Study polysomnography and sleep apnea treatment as indicated
   (Screening protocol completed and all appointments coordinated by SWL staff)

Signature of the Referring Provider: _____**Printed Name:**_____

Phone #: _____ **Fax #:** _____ **Date of referral:** _____

Mail /fax this form along with a recent H/P and recent OV notes to:

Northern Light Surgical Weight Loss, 905 Union Street, Suite 11, Bangor, ME 04401:
Phone 973-6383 Fax 973-7364