EMMC Surgical Weight Loss Program Referral Form

Patient Name: ____ DOB:____/____/____
Social Security#____
Address: ____ City/Zip:____________________
Phone: (H)__________________ (W) __________________(Cell)____________________
Primary Insurance (PLEASE SEND COPY OF CARD):
Name/certificate/group#____

____

Secondary Insurance
Name/certificate/group#____

____

Relative contraindications to gastric bypass surgery (please check✓):

Smoking* Yes or No ☐ Repeated no-shows for scheduled office visits

☐ Significant psychiatric diagnosis ☐ Active drug/alcohol/prescription narcotic abuse**

***As of 08/08 we can no longer accept referrals on patients who smoke. Your office must provide documentation regarding smoking cessation before we can begin the program.**

Pt. Height: __________ Pt. Weight: __________ Body Mass Index: _______

Indications for referral:

☐ Morbid obesity (Body Mass Index ≥ 40)

☐ Obesity (Body Mass Index 35-39.9 with 1 of the following :heart disease, type 2 diabetes, poorly controlled HTN, obstructive sleep apnea (latter two must be treated)

Comorbid Diagnosis:

☐ Diabetes (Last HgA1C= ________)* ☐ Cardiovascular disease

☐ Hypertension ☐ Fatty Liver ☐ Venous stasis ulcers/cellulitis

☐ Hyperlipidemia ☐ Chronic pain (please indicate where:____________________)

☐ GERD ☐ Osteoarthritis

☐ Sleep apnea (If checked please indicate current treatment________________________________)

☐ PCOS ☐ Other:________________________________

*HbA1C must be ≤ 8 to proceed to surgery

Past treatments for weight loss/control:

☐ Diet therapy (documented attempts at therapy by MD, DO, PA, NP, RD)

☐ Weight Loss Medications (please list: ________________________________)

☐ Prior weight loss surgery; What year______________What surgery: ____________________

(operative reports or discharge summaries helpful if the patient has had prior weight loss surgery. May need UGI study to determine if reoperation is an option).

Present Medications: **Please send medication list**

Procedure Requested:
☐ **Gastric Bypass Surgery**
☐ **Adjustable Gastric Band**
☐ **Sleeve Gastrectomy**

Bariatric Surgeon Preference (leave blank if no preference):

☐ *Dr. Michelle Toder* ☐ *Dr. Fariba Dayhim* ☐ *Dr. Michael St. Jean*

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 by SWLP personnel and Appointment coordinated by SWLP)

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

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

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

SWLP, 905 Union Street, Suite 11, Bangor, ME 04401: Phone 973-6383 Fax 973-7364