Stamp physician name and address

Please fax completed form to (716) 565-3988

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):** _____

_____

_____

TSH Level (Within last 6 months, if available) _____

***Current prescription and over the counter medicines with dose and instructions (please attach additional sheet if necessary):

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.

_____ _____
Print name of Physician Date

_____
Signature

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