# Bariatric Surgery Program
# Referral

**Has your patient had previous weight loss surgery?** ☐ Yes ☐ No

| | |
|---|---|
| Patient Name: | Weight: |
| PHN: | |
| Date of Birth: | Height: |
| Phone: (H) | |
| Phone: (C) | BMI: |
| Address: | |
| Primary Care Provider: | Smoker: ☐ Yes ☐ No |

**MANDATORY REQUIREMENTS (PLEASE CHECK THE ONE THAT APPLIES)**

☐ BMI > 40 **OR** ☐ BMI > 35 plus medical co-morbidities **AND** ☐ Age 18 – 65 Years

**RISK FACTORS – Please check ALL that apply**

| | | |
|---|---|---|
| ☐ Type 2 diabetes | ☐ Osteoarthritis | ☐ Pseudotumor Cerebri |
| ☐ Depression | ☐ Hyperlipidemia | ☐ Cardiovascular Disease |
| ☐ Other Psychiatric history | ☐ Chronic Pain | ☐ Severe Immobility |
| ☐ Obstructive Sleep Apnea | ☐ Fatty Liver | ☐ Venous Stasis/recurrent cellulitis |
| ☐ Hypertension | ☐ GERD | ☐ Asthma |

PAST MEDICAL HISTORY (SUMMARY/LIST):

CURRENT MEDICATIONS:

PSYCHOLOGICAL CONCERNS/ CONSIDERATIONS: PHQ9 score if done: _____

PLEASE INCLUDE COPIES OF MOST RECENT:

☐ Bloodwork ☐ Cardiac work up (If applicable) ***SLEEP STUDY RESULTS (REQUIRED)***

☐ ECG ☐ Medication List

Referral source / Authorized name and signature:

| | |
|---|---|
| Title (Profession): | Date Signed: |

**ROUTING**

Bariatric Program, Memorial Pavilion, Homer 120, Royal Jubilee Hospital 1952 Bay St Victoria V8R 1J8

Phone: 250-370-8641 **Fax: 250-370-8661**

**FOR OFFICE USE ONLY**

**PRIORITY:**

**DATE RECEIVED:**