Bariatric Surgery Program

Referral Form

Has your patient had previous weight loss surgery? ☐ Yes ☐ No	
Patient Name:	Weight:
PHN:	
Date of Birth:	Height:
Phone: (H)	
Phone: (C)	BMI:
Address:	
Family Doctor:	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: