

**PRIMARY CARE PHYSICIAN REFERRAL FORM**

(Must be filled out by your physician)

Dear New Life Weight Loss & Advanced Laparoscopic Surgery,

I am referring my patient \_\_\_\_\_, date of birth \_\_\_\_\_, to you for your opinion regarding the possibility of weight loss options, including surgery. The patient's current weight is: \_\_\_\_\_ lbs, height is: \_\_\_\_\_ ft \_\_\_\_\_ in, BMI is: \_\_\_\_\_ kg/msq. The patient has been morbidly obese for \_\_\_\_\_ years.

The patient suffers from the following co-morbid conditions associated with morbid obesity which include: (check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Type 2 diabetes – controlled by oral medications       | <input type="checkbox"/> Dyslipidemia                      |
| <input type="checkbox"/> Type 2 diabetes – controlled by injectable medications | <input type="checkbox"/> Stress incontinence               |
| <input type="checkbox"/> Obstructive sleep apnea                                | <input type="checkbox"/> GERD                              |
| <input type="checkbox"/> Coronary artery disease _____                          | <input type="checkbox"/> Heart burn                        |
| <input type="checkbox"/> Valvular heart disease                                 | <input type="checkbox"/> Arthritis                         |
| <input type="checkbox"/> Hypertension   | <input type="checkbox"/> History of medical non-compliance |

The patient also has the following conditions that are associated with morbid obesity:

\_\_\_\_\_

The patient has a current/history of:

- |  |   |
|--|---|
| <input type="checkbox"/> Schizophrenia, psychosis, thought disorders | <input type="checkbox"/> Suicide attempts or psychiatric hospitalizations |
| <input type="checkbox"/> Consistent difficulty in coping with stress | <input type="checkbox"/> Substance abuse or eating disorders              |

I have completed the following diagnostic work up on this patient **in the past year**. I will be forwarding a copy of these reports to your office to assist with your evaluation of my patient (please check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Sleep study  | <input type="checkbox"/> Pulmonary function test |
| <input type="checkbox"/> Exercise Stress Test                                 | <input type="checkbox"/> Venous duplex           |
| <input type="checkbox"/> Laboratory testing such as a lipid panel and Hgb A1C | <input type="checkbox"/> Other: _____            |

**The patient has attempted other weight reduction alternatives and has been unsuccessful in maintaining adequate weight loss. Please render your opinion on appropriate management options.**

Sincerely,

\_\_\_\_\_  
Signature (required)

\_\_\_\_\_  
Date

(\_\_\_\_\_) \_\_\_\_\_  
Phone

\_\_\_\_\_  
Printed Name

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Address (required)

**Please attach the most recent Office Visit Note which includes current medications, medical and surgical history**