SSM Weight-Loss Institute
DEPAUL HEALTH CENTER

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314.344.6800 Phone
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ssmweightloss.com

PRIMARY CARE PHYSICIAN REQUEST FORM

Dear SSM Weight Loss Institute,

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: _______, height is: ________, BMI is: __________. The patient has been morbidly obese for ______ years.

The patients five (5) year weight history:

(1) Yr: _______ Wt: _______ (2) Yr: _______ Wt: _______ (3) Yr: _______ Wt: _______

(4) Yr: _______ Wt: _______ (4) Yr: _______ Wt: _______

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

- ☐ Type 2 diabetes – controlled by oral medications
- ☐ Type 2 diabetes – controlled by injectable medications
- ☐ Obstructive sleep apnea
- ☐ Coronary artery disease
- ☐ Valvular heart disease
- ☐ Hypertension
- ☐ Dyslipidemia
- ☐ Stress incontinence
- ☐ GERD
- ☐ Heart burn
- ☐ Arthritis
- ☐ History of medical non-compliance

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

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

The patient's previous weight loss attempts:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

TSH Required. Other tests listed optional, please provide results if applicable.

- ☐ Laboratory testing such as lipid panel, HGB A1C, TSH (Required)
- ☐ Sleep Study
- ☐ Exercise stress test
- ☐ Pulmonary function test
- ☐ Venous duplex
- ☐ Other: __________________________

This 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)

SSM DePaul Health Center