

To be completed by your primary care physician
PRIMARY CARE PHYSICIAN REQUEST FORM

This form can be forwarded to your physician and requested to be faxed to the fax number listed at the top of the page when complete. You do not need to wait for this form to be completed to return the rest of the packet. We will match all items in the office once received.

Dear SSM Health Weight Management Services,

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 patient's five (5) year weight history:

(1) Yr: _____ Wt: _____ (2) Yr: _____ Wt: _____ (3) Yr: _____ Wt: _____
(4) Yr: _____ Wt: _____ (5) 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 - Need most recent HGBA1C drawn attached
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. I recommend this patient for weight loss surgery.

Sincerely,

Physician Signature (Required) Date Phone
Printed Name
Address (Required)