Primary Care Physician Documentation for Bariatric Surgery Approval

BRING THIS TO YOUR PRIMARY CARE PROVIDER

Patient Name:	Date of Birth
I am referring this patient to you for consideration of Weight Loss Surgery for Morbid Obesity:	
The patient has been Morbidly Obese for the following years:	
My patient's height is (in inches):	
My patient's last recorded weight is (in lbs.):	
My patient's BMI is:	

My patient has the following co-morbidities:

☐ Type 2 Diabetes	☐ Sleep Apnea	☐Pulmonary Disease
☐Hypertension	☐Osteoarthritis	☐Major Mental Health Condition
☐Chronic Pain	☐Hyperlipidemia	☐Major GERD
☐Inflammatory Bowel Disease		
☐Other (please list):		

☐There is no significant liver, kidney, or gastrointestinal disease present

☐There is no treatable cause for obesity such as adrenal or thyroid disorder

TSH Level (within last 6 months): _____

☐There are no cardiac or pulmonary contraindications to bariatric surgery

☐There is no history of alcohol or substance abuse

*** (IF ANY BOX REMAINS UPCHECKED, PLEASE ADDRESS WHY)

_____

_____

_____

The patient is medically cleared for surgery:

☐Yes ☐No

If no, please address what further treatment patient will need to be cleared for surgery:

_____

PLEASE ATTACH A COPY OF ALL RECENT LAP RESULTS AND CURRENT MEDICATIONS

By signing this form, I believe this patient is a good candidate for surgery and would benefit from significant weight loss.

Provider Name: _____

Signature_____ Date_____

Please fax completed form and requested records to 801-268-3997

ROCKY MOUNTAIN
ASSOCIATED PHYSICIANS
WEIGHT & METABOLISM
CENTER