1521 East 3900 South, Suite 100
Salt Lake City, Utah 84124
801-268-3800
info@rmapinc.com
rmap.com

ROCKY MOUNTAIN
ASSOCIATED PHYSICIANS
WEIGHT & METABOLISM CENTER

Rodrick D McKinlay, MD
Nicholas J Paulk, MD, FACS, ABOM
Douglas C Greer, MD , FASMBS
Elizabeth Hanna, APRN
Ailien Luu, FNP
Stacy Parry, FNP

Referral Form

1. Patient Information

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Height: _____ Last recorded weight _____ lbs on ___/___/_____ BMI: _____

Insurance: _____ Group #: _____ Policy #: _____

Referral For: ☐ Medical Weight Loss ☐ Bariatric Surgery ☐ Other _____

2. Include any information provided by the patient regarding weight loss attempts.

Program (Nutri Sys, WW, So Beach, etc.)	Year	Number of months the program was followed	Supervised by Doctor? Y/N	Total weight loss using this program

3. Patient has the following co-morbidities:

☐ Hypertension ☐ Diabetes ☐ Coronary Disease ☐ Pulmonary Disease
☐ Sleep Apnea ☐ Degenerative Arthritis ☐ Other

4. Patient has any of the following:

☐ Liver Disease ☐ Hx of DVT/PE ☐ Kidney Disease ☐ Gastrointestinal Disease

5. Uses tobacco. ☐ No ☐ Yes: Amount/Freq _____ Date Quit _____

6. Uses alcohol. ☐ No ☐ Yes: Amount/Freq _____ Date Quit _____

7. Uses illicit drugs. ☐ No ☐ Yes: Amount/Freq _____ Date Quit _____

8. My patient is generally compliant with follow-up appointments, medications and health care recommendations. ☐ Yes ☐ No

Please attach a list of the patient's current medication regimen.

*If referring for bariatric surgery, by signing this form, I, as the patient's physician, am recommending Bariatric Surgery and am indicating that the patient is medically cleared for surgery.

_____ _____
Printed name of Physician Phone

_____ _____
Signature of Physician Date

Please Fax this completed form to (801) 268-3997