Letter of Referral for Weight Loss Surgery

This form must be completed upon completion of the Physician Supervised Weight Loss Visits

Completed forms should be scanned into the EMR and FAXED to 833-715-6611

Patient Name: _____ Patient DOB: _____

The patient named above is a patient of mine with a longstanding history of obesity that has been refractory to medical weight loss regimens. The patient's obesity related comorbidities include:

- ❑ Diabetes
- ❑ Hypertension
- ❑ Sleep Apnea
- ❑ Other:

_____

_____

_____

The patient's additional medical history is significant for:

_____

_____

_____

The patient's most recently recorded height and weight:

Height: _____ Weight: _____ BMI: _____ Date: _____

My patient is motivated to make lifestyle changes required to maximize the likelihood of successful, sustained weight loss, and would therefore benefit from weight loss surgery to improve their overall health, quality of life, and to minimize their risk of obesity related comorbidities. In my opinion, weight loss surgery for this patient is medically necessary to treat the above comorbidities.

My patient is able and willing to be compliant with the necessary post-procedural dietary restrictions.

Please evaluate my patient as a candidate for weight loss surgery.

If considered an appropriate candidate:

- ❑ The patient has been evaluated and deemed medically optimal to proceed with surgery
- ❑ I will need to see the patient back again in the office for formal pre-operative clearance

Provider Signature: _____ Date: _____

I have also enclosed documentation of prior weight loss efforts and the patient's weights at our office.

AdventHealth Redmond