Fax Cover Sheet

To: THE COMPREHENSIVE WEIGHT MANAGEMENT CENTER

Holston Valley Medical Center
9th Floor Parking Garage, Suite 9I
P.O. Box 238 Kingsport, TN 37662
Phone: 423-224-5361 ***Fax: 423-224-4974***

Date: _____ # Pages w/ cover sheet: _____

From: Referring Physician/NP: _____

Office address: _____

Office phone #: _____ Office fax #: _____

Info by: (name/title) _____

Please evaluate the patient for weight loss (bariatric) surgery as marked:
✓ box for requested service.
□ Gastric Bypass □ Sleeve Gastrectomy
□ Laparoscopic Adjustable Gastric Banding

Patient name: _____ Date of birth: _____

Age: _____ Sex: _____ Height: _____ Weight: _____ BMI: _____
(Note: General criteria is age 18-65. Age >65 requires further review.)

Address: _____

Home phone #: _____ Cell #: _____

Work#: _____ SSN# _____

Insurance: _____

***Please fax front and back of the insurance card along with this referral form. Request referral form completion and insurance card only at this time. No other records needed. Thank you!**

Weight-associated co-morbid conditions & risk factors: ✓ if applicable.

□ CAD □ DM - Type 2 □ Obstructive sleep apnea □ CPAP □ Bi-PAP

□ HTN □ Dyslipidemia □ Pre-DM □ + Family hx for early CVD
Comments:
_____