SSMHealth
In partnership with the Felician Sisters | Weight Management Services

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 complete and faxed to 618-436-6105.

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)

- o Type 2 diabetes – Need most recent HGBA1C drawn attached
- o Obstructive sleep apnea
- o Coronary artery disease
- o Valvular heart disease
- o Hypertension
- o Dyslipidemia
- o Stress incontinence
- o GERD
- o Heart burn
- o Arthritis
- o History of medical non-compliance
- o _____
- o _____

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.

- o Laboratory testing such as lipid panel, HGB A1C, TSH (Required)
- o Sleep Study
- o Exercise stress test
- o Pulmonary function test
- o Venous duplex
- o 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)

(12/2015)