



Referral for Bariatric Surgery Program

Bariatric Program | Memorial Pavilion | Homer 120 | Royal Jubilee Hospital 1952 Bay St Victoria V8R 1J8

Fax: 250-370-8661 | Phone: 250-370-8641

Has your patient had previous weight loss surgery? Yes / No	
Patient Name:	Weight:
PHN:	
Date of Birth:	Height:
Phone: (H)	
Phone: (C)	BMI:
Address:	
Family Doctor:	Smoker: Yes / No

MANDATORY REQUIRMENTS (PLEASE CHECK THE ONE THAT APPLIES)

BMI>40 **OR** BMI>35 plus medical co-morbidities

RISK FACTORS – Please check ALL that apply

<input type="checkbox"/> Type 2 diabetes	<input type="checkbox"/> Fatty Liver
<input type="checkbox"/> Depression	<input type="checkbox"/> GERD
<input type="checkbox"/> Other Psychiatric history	<input type="checkbox"/> Pseudotumor Cerebri
<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Cardiovascular Disease
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Severe Immobility
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Venous Stasis/recurrent cellulitis
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Asthma
<input type="checkbox"/> Osteoarthritis	

PAST MEDICAL HISTORY (SUMMARY/LIST):

CURRENT MEDICATIONS:

PSYCHOLOGICAL CONCERNS/ CONSIDERATIONS: PHQ9 score if done: _____

PLEASE INCLUDE COPIES OF MOST RECENT:

1. Blood work	4. Medication List
2. ECG	5. SLEEP STUDY RESULTS (REQUIRED)
3. Cardiac work up (If applicable)	

Referral source / Authorized name and signature:

Title (Profession):	Date Signed:
---------------------	--------------

FOR OFFICE USE ONLY
PRIORITY:
DATE RECEIVED: