PeaceHealth

***FAX ALL REQUIRED FORMS TO (541) 222-6113 FOR SUBMISSION

PHMG BARIATRIC SURGERY REFERRAL FORM

PHMG PT LABEL

If patient is experiencing NON-URGENT, ACUTE ISSUES (ex. Inability to eat/drink, persistent nausea/vomiting, abdominal pain) RELATED TO A PRIOR BARIATRIC SURGERY, DO NOT USE THIS FORM. Visit our website https://www.peacehealth.org/locations/springfield/peacehealth-bariatric-and-general-surgery-center-riverbend-pavilion for more information on PHMG Bariatrics.

PATIENT NAME:	**DOB:**	**AGE:**
REFERRING PROVIDER: ☐ **NON-PHMG PROVIDER** ☐ **PHMG PROVIDER**	**REFERRAL DATE:**	**WEIGHT (lbs.) + DATE OBTAINED:**
PCP (if different from referring provider):	**HEIGHT: ft. in.**	**BMI: kg/m2**

ALL REFERRALS MUST BE ACCOMPANIED BY:

☐ Completed referral form **AND** most recent FULL history

☐ Patient detailed demographics sheet **AND** current insurance

Please indicate: ☐ No Prior Authorization required

☐ Prior Authorization Obtained

Auth/Reference#: _____ **Dates Authorized:** _____ **Visits Authorized:** _____

☐ Preferred patient pharmacy: _____

☐ Patient problem list **AND** current medication list

☐ Additional documentation as indicated based on reason for referral (see below)

☐ **Patient with NO history of bariatric surgery**	☐ **Patient HAS history of bariatric surgery**
Additional documentation for bariatric evaluation: ☐Completed section 1 & 2 of this form ☐Recent chart note (within last 6 months) documenting obesity diagnosis **AND** patient interest in bariatric surgery **Date of Provider consult:** _____ **Was this consult with patient's PCP?** ☐ **YES** ☐ **NO** ☐Negative urine cotinine test if nicotine quit date is in past **90 DAYS**	**Additional documentation for establishing care:** ☐Operative Report – provided by patient **Procedure Type:** _____ **Procedure Date:** _____ **Location:** _____ **Surgeon:** _____ ***We are unable to treat patients who originally had surgery anywhere outside of the country.**

☐ **PATIENT HAS NO INTEREST IN SURGERY – PLEASE EVALUATE FOR MEDICAL WEIGHT LOSS.**

SECTION 1: MINIMUM REQUIREMENTS FOR NEW EVALUATION. ALL MUST BE MET BEFORE INITIATING REFERRAL.

ALL BOXES MUST BE CHECKED FOR REFERRAL TO BE ACCEPTED:

☐ **AGE REQUIRMENT:** 18 – 74 YEARS

☐ **BMI:** < 70, ≥ 35

☐ **NICOTINE FREE** – in all forms

☐ Minimum 1-year post-partum, if applicable.

☐ **NO** psychiatric hospitalizations in the past 1 year

☐ **NO** self-harm or suicide attempts in the past 2 years

☐ **NO** illicit drug use OR alcohol abuse/misuse in the last 2 years

Referring provider signature: I certify that patient meets ALL criteria. X_____

☐ ***This referral was sent internally by a PHMG provider and reviewed by PHMG Bariatrics office staff.***

SECTION 2: ADDITIONAL INFORMATION

A. PRESENCE OF OBESITY RELATED CONDITIONS – CHECK ALL THAT APPLY:

☐ Diabetes mellitus – Type 1 or 2

☐ Hypertension

☐ Sleep apnea

☐ Arthritis/degenerative joint disease in major weight bearing joints

☐ Gastroesophageal reflux disease

☐ Hyperlipidemia

☐ Fatty liver disease/NASH

☐ Pseudotumor cerebri/ Idiopathic intracranial hypertension

☐ Polycystic ovarian syndrome

☐ Congestive heart failure

☐ **PATIENT HAS NO CO-MORBIDITIES**

B. NICOTINE STATUS *(IN ALL FORMS)* – ☐ **NEVER USED NICOTINE** ☐ **CURRENT USER** ☐ **FORMER USER, QUIT DATE:** _____

**** If quit date is < 90 DAYS from time of referral, a negative urine cotinine test is required with the referral.**

Have you submitted a nicotine/cotinine lab for your patient? Date Orders Placed: _____ *Testing Facility:* _____

PLEASE FAX RESULTS TO (541) 222-6113

SECTION 3: FOR PHMG BARIATRICS OFFICE USE ONLY	COORDINATOR INITALS:	DATE OF REVIEW:

A. COMORBIDITIES

BMI: _____

☐ HTN ☐ HLD ☐ DM ☐OSA ☐ GERD ☐PCOS ☐CHF/CAD ☐ CKD ☐ NASH/FATTY LIVER/CIRRHOSIS
☐MOBILE/NOT WHEELCHAIR BOUND ☐ OA IN WEIGHT BEARING JOINTS

B. INSURANCE

PRIMARY: _____
SECONDARY: _____
INSURANCE CRITERIA:

NICOTINE SCREEN: ☐ YES ☐ NO
TOXICOLOGY SCREEN: ☐ YES ☐ NO

C. NOTES

D. SURGICAL EVALUATION:

DATE:	EVA TIME:	PROVIDER: