



DataFax #102

Plate #001

Visit #001

Bariatric Registry - Referral Form Page 1 of 1

Patient Initials [][] [][] [][]
F M L

Referral ID# [][][][][][] [][][][]
Physician Referral # Patient #

Date Form Completed: 2 0 [][] [][] [][]
year month day

1. Patient Name: Last/Family Name First Name Middle Name

2. Home Address: Apt. No. Street Town/City Province/State Postal Code

3. Home Phone: [][][] [][][] - [][][][] 4. Cell/Work Phone: [][][][] [][][][] - [][][][][] NA

5. Referring Physician/Health Care Provider: Tel: [][][][] [][][][] - [][][][][]
Physician's OHIP Billing No: [][][][][][] Fax: [][][][][] [][][][][] - [][][][][][]

Is the Referring Physician the patient's Family Physician? No Yes

6. Health Card #: [][][][][][][][][][][][][][][][] (ON Version Code)
7. Gender: Male Female
8. Date of Birth: [][][][] [][][] [][][]
year month day

Questions 9-25 to be completed by physician or nurse practitioner:

9. Current Weight: [][][][] • [][] kg Actual Estimated 10. Height: [][][][] • [][] cm Actual Estimated
[][][][] lbs [][][][] inches Estimated

- 11. Does the patient currently have a significant psychiatric illness? No Yes Treated Untreated Patient not eligible for referral
12. Does the patient currently smoke? No Yes Patient not eligible for treatment until abstinent for at least 6 months
13. Does the patient currently have a problem with alcohol or other drugs? No Yes Patient not eligible for treatment
14. Did the patient agree to be referred to the program? No Yes If NO, patient not eligible for referral

- 15. Has the patient had Bariatric (weight loss) surgery (not liposuction) or Upper G.I. surgery? No Yes
16. Is the patient's excess weight delaying weight bearing joint replacement surgery? No Yes
17. Does the patient have significant issues performing their Activities of Daily Living or their employment duties due to their obesity? No Yes
18. Has the patient tried the behavioural programs that conform to the Canadian Clinical Practice Guidelines on the management of obesity that are available to them in their own community? No Yes
19. Does the patient have type 2 diabetes or impaired fasting glucose? No Yes
20. Does the patient have hypertension that is not adequately controlled on 2 or more medications? No Yes
21. Does the patient have dyslipidemia that is not adequately controlled with medical therapy? No Yes
22. Does the patient have sleep apnoea that is not adequately controlled with a CPAP device? No Yes
23. Does the patient have gastroesophageal reflux not adequately controlled on medical therapy? No Yes
24. Does the patient have end stage renal disease or require dialysis? No Yes
25. Does the patient have severe cardiac or respiratory disease? No Yes

Physician Completing Report: Print last name/first initial Signature

Please Fax Completed Form to One (1) of these Centres

- Guelph.....519-837-6773
Humber.....416-747-3731
Ottawa.....613-761-5343
SJHH.....905-521-6152
Toronto West...416-603-5142
Windsor.....519-971-9566