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Visit our website: <https://www.myhorizonhealth.org/services/center-for-weight-management/> for more information.

|                      |                             |                          |
|----------------------|-----------------------------|--------------------------|
| <b>PATIENT NAME:</b> | <b>DOB:</b>                 | <b>AGE:</b>              |
| <b>WEIGHT (lbs.)</b> | <b>HEIGHT:</b> ft.      in. | <b>BMI:</b>              |
| <b>INSURANCE:</b>    | <b>INSURANCE MEMBER ID:</b> | <b>INSURANCE GROUP #</b> |

**ALL REFERRALS MUST BE ACCOMPANIED BY:**

- ☐ Completed referral form **AND** most recent FULL history
- ☐ Patient detailed demographic sheet **AND** copy of current insurance card
- ☐ Patient problem list **AND** current medication list
- ☐ Additional documentation as indicated based on reason for referral (see below)

| <b>SECTION 1: REASON FOR REFERRAL</b>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Patient with No history of bariatric surgery<br><br>Additional documentation for bariatric evaluation<br><input type="checkbox"/> <b>Complete section 1 &amp; 2 of this form</b><br><input type="checkbox"/> Recent chart note (within the last 6 months) documenting obesity diagnosis & patients interest in bariatric surgery | <input type="checkbox"/> Patient HAS history of bariatric surgery<br><br>Additional documentation for establishing care:<br><input type="checkbox"/> Operative Report<br>Procedure Type: _____<br>Procedure Date: _____<br>Location: _____ Surgeon: _____<br><input type="checkbox"/> Re-establish routine post-operative care<br><input type="checkbox"/> Seeking revision/conversion of prior bariatric surgery<br>Reason: _____ | <input type="checkbox"/> Medical Weight Management<br><br>Additional documentation for MWM<br><input type="checkbox"/> Hx of oral weight loss meds<br>Medication: _____<br><input type="checkbox"/> Hx of injectable weight loss meds<br>Medication: _____<br><input type="checkbox"/> Never tried weight loss meds |

**SECTION 2: MINIMUM REQUIREMENTS FOR NEW EVALUATION. ALL MUST BE MET BEFORE INITIAL REFERRAL (ONLY FOR NEW BARIATRIC PATIENT REFERRALS)**

- ☐ AGE REQUIREMENT: 18-75
- ☐ BMI > 35 WITH CO-MORBIDITY
- ☐ BMI > 40
- ☐ NO PSYCHIATRIC HOSPITALIZATIONS IN THE PAST YEAR

**SECTION 3: ADDITIONAL INFORMATION (COMPLETE FOR ALL REFERRALS)**

A. Presence of Obesity-Related Conditions: **Mark all that apply:**

- |                                                                                              |                                                                                   |
|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> Diabetes Mellitus – Type 1 or 2                                     | <input type="checkbox"/> Asthma/COPD                                              |
| <input type="checkbox"/> Hypertension                                                        | <input type="checkbox"/> Cardiovascular Disease                                   |
| <input type="checkbox"/> Sleep apnea                                                         | <input type="checkbox"/> Venous stasis disease                                    |
| <input type="checkbox"/> Arthritis/degenerative joint disease in major weight bearing joints | <input type="checkbox"/> Nonalcoholic fatty liver disease or steatohepatitis/NASH |
| <input type="checkbox"/> Hyperlipidemia                                                      | <input type="checkbox"/> <b>PATIENT HAS NO CO-MORBIDITIES</b>                     |

B. Nicotine status (all forms)-

- ☐ Never used nicotine
- ☐ Current nicotine user: Years \_\_\_\_\_
- ☐ Former nicotine user: Quit date \_\_\_\_\_

Referring provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Address: \_\_\_\_\_ Provider Phone Number: \_\_\_\_\_