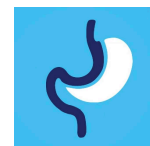




**TRURO OBESITY CARE TEAM
REFERRAL FORM**

Phone: (902) 673-3211

Fax: (902) 453-0525



Name:
Date of Birth (yyyy/mm/dd):
Phone (cell):
Email:

Health Card:
Phone (work):
Family Doctor/
NP:

Referral Type:

Consultation only

Consultation and consideration for bariatric surgery

Medical weight management only

Health History:

Weight: lb, kg Height: ft in, m
BMI: Waist: in

Check what corresponds to your patient's health

Current Medical Conditions:

Type 2 Diabetes
Hypertension
Obstructive Sleep Apnea
Dyslipidemia
GERD
PCOS
Osteoarthritis
Depression/Anxiety
MAFLD
Other:

Current Weight Loss Medication:

Wegovy
Ozempic
Contrave
Other:

Has patient had previous weight-loss surgery? **YES NO**
If yes, please provide type, name of surgeon, date, weight outcomes:

Relevant Investigations:

Recent bloodwork (within 6 months)
Sleep study results, if applicable
EKG
Abdominal Ultrasound / CT / MRI
Endoscopy (if GERD symptoms)
Other:

Bariatric Surgery Considerations:

BMI ≥ 30 with associated co-morbidities
BMI ≥ 35 kg/m² with or without co-morbidities
Committed to follow-up with our Team for a minimum of 3 months preoperatively AND long-term postoperatively
Committed to taking vitamin supplements for life
Committed to adopting healthy lifestyle habits before and after surgery

Bariatric Surgery Contraindications:

Acute or unstable mental health (stable mental health for 12 months required prior to surgery)
Smoking (cessation for 3 months required prior to surgery)
Alcohol or drug dependence (sobriety for 6 months required prior to surgery)
Lack of motivation

Comments:

Referring Provider's Signature:

Referring Provider's Name:

Date (yyyy-mm-dd):