TRURO OBESITY CARE TEAM
REFERRAL FORM

Phone: (902) 673-3211
Fax: (902) 453-0525

Name: _____ Health Card: _____
Date of Birth (yyyy/mm/dd): _____ Phone (work): _____
Phone (cell): _____ Family Doctor/
Email: _____ 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): _____