Manatee Surgical Alliance

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Physician Referral Form for Bariatric Surgery

OFFICE INFORMATION				
Today's date:	Physician Referring:	Office Number:	Fax Number:	
Street address:		City:	State:	ZIP Code:

PATIENT INFORMATION				
Last name:	First:		Middle:	
Street address:		City:	State:	ZIP Code:
Home phone:	Cell:	Work:	Email:	
( )	( )	( )		
Height in Inches:	Weight in Pounds:		BMI	

INSURANCE INFORMATION		
Primary Insurance:	Subscriber:	Policy #:
Secondary Insurance:	Subscriber:	Policy #:

MEDICAL HISTORY		
Please attach all pertinent medical records	Yes	No
1. Has patient been medically cleared for all co-morbidities?	❑	❑
2. Has patient been evaluated for hypothyroidism or other endocrinopathology?❑	❑	❑
3. Has patient received cardiac clearance for surgery?	❑	❑
4. Has patient had an evaluation for h. pylori if patient was symptomatic for GERD or gastric reflux?	❑	❑
5. Has patient completed a physician supervised diet with monthly weigh-ins?	❑	❑
6. Has patient completed a supervised exercise program?	❑	❑
7. Does the patient use tobacco?	❑	❑
8. Has the patient had previous Bariatric Surgery?	❑	❑

Please attach any other pertinent Information and Fax to 941-254-4958