Southern Oregon Bariatric Center

If patient experiencing NON-URGENT, ACUTE ISSUES (ex. inability to eat/drink, persistent nausea/vomiting, abdominal pain) RELATED TO A PRIOR BARIATRIC SURGERY, DO NOT USE THIS form. REFER DIRECTLY to Oregon Surgical Specialists.

SOBC REFERRAL FORM

Patient Name:	Date of Birth:	Age:
Current weight: lbs Date obtained:	Height: ft in	BMI: kg/m^2

ALL REFERRALS MUST BE ACCOMPANIED BY:

- Patient demographic sheet with insurance information.
- Recent chart note clearly documenting reason for referral, active/past problem list, and current medication list.

Referring Provider: _____ Date of Referral: _____

☐ Referral for **Bariatric Surgery**

A. **Does patient have a history of bariatric surgery?** ☐ **No**-Proceed to Step B ☐ **Yes**- Proceed to Step C

B. **For patients seeking new evaluation for consideration of bariatric surgery.** Chart note must include documentation of obesity diagnosis and patient interest in bariatric surgery.

BMI requirements (Select one)

☐ BMI ≥ 35 kg/m^2

☐ BMI 30-34.9 kg/m^2 with Type 2 diabetes not meeting glycemic targets despite appropriate medical therapy

Minimum requirements for new evaluation

- Age ≥ 18
- No alcohol use disorder (AUD) or substance use disorder (SUD) within the past year
- No severe, uncontrolled, or unmanaged mental health disorders.

☐ **I certify that patient meets ALL minimum criteria.**

Is patient currently using nicotine products in any form including: combustible nicotine (cigarettes, cigars, pipes), e-cigarettes or smokeless nicotine products (chewing tobacco, nicotine gum, patches, or lozenges)?

☐ No

☐ Yes. Is patient willing to stop use? ☐ Yes ☐ No

*Use of any nicotine-containing product is NOT permitted for at least 3 months prior to bariatric surgery. SOBC reserves the right to require nicotine/cotinine testing if indicated.

C. **For patients seeking evaluation due to a history of bariatric surgery.**

Did the patient have original surgery with SOBC? ☐ Yes ☐ No

If no, prior surgery type, date, who/where performed: _____

Reason for referral (select one)

☐ Seeking revision/conversion of a prior bariatric surgery

Reason: ☐ Inadequate weight loss ☐ Weight re-gain ☐ GERD ☐ Other (specify): _____

☐ Seeking to establish ROUTINE post-operative care

Our clinic is not able to assume routine care of patients that had surgery at another bariatric clinic within the state of Oregon, Northern CA, or outside of the U.S. Direct patient to follow-up with original bariatric clinic.

☐ Evaluate for NON-URGENT bariatric surgery related complications, specify: _____

☐ Referral for **Bariatric Medicine (Non-surgical medical weight management with FNP & RD)**

Minimum requirements for new evaluation.

- Age ≥ 18
- BMI ≥ 35 kg/m^2 OR BMI 30-34.9 kg/m^2 with Type 2 diabetes
- No severe, uncontrolled, or unmanaged mental health disorders.

☐ **I certify that patient meets ALL minimum criteria.**

FAX ALL REQUIRED DOCUMENTATION TO (541) 245-4808.

For more information, please visit our website at www.sobariatrics.com and click on "Referring Providers" tab.