Southern Oregon Bariatric Center

If patient is 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.

REFERRAL FORM: BARIATRIC SURGERY

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

ALL REFERRALS MUST BE ACCOMPANIED BY:

☐ Completed referral form AND recent chart note
☐ Patient demographics sheet with insurance information
☐ Patient problem list AND current medication list
☐ Additional documentation as indicated based on reason for referral (see below)

SECTION 1: REASON FOR REFERRAL

Referring Provider: _____ Date of Referral: _____

☐ **Patient with NO history of bariatric surgery**	☐ **Patient HAS history of bariatric surgery**
New evaluation for bariatric surgery **Additional documentation required:** ● Completed Section 2 and 3 of this form. ● Recent chart note (within past 6 months) documenting diagnosis of obesity and patient interest in bariatric surgery. ● Negative urine cotinine test if nicotine quit date in past 12 months.	☐ Seeking revision/conversion of a prior bariatric surgery Reason: _____ ☐ Re-establish routine post-operative care Previous SOBC patients only. We are unable to assume care for routine post-operative patients who did not have their original surgery with SOBC. **Additional documentation required:** ☐ Chart note (within past 6 months) documenting indication for referral.

SECTION 2: MINIMUM REQUIREMENTS FOR NEW EVALUATION. ALL MUST BE MET BEFORE INITIATING REFERRAL.

- NO history of prior bariatric surgery
- Age 21-75
- BMI ≥ 35
- NICOTINE-FREE
- NO unstable mental or behavioral health conditions
- NO illicit drug use in the past 2 years
- NO alcohol abuse or misuse in the past 2 years
- NO self-harm or suicide attempt in past 5 years

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

SECTION 3: ADDITIONAL INFORMATION

A. Presence of Obesity-Related Conditions (ORCs): Mark all that apply.

☐ Type 2 diabetes mellitus
☐ Hypertension
☐ Sleep apnea
☐ Coronary artery disease
☐ Arthritis/degenerative joint disease in major weight-bearing joints (documented by abnormal x-rays)
☐ Gastroesophageal reflux disease
☐ Hyperlipidemia
☐ Insulin resistance, pre-diabetes, or metabolic syndrome
☐ Asthma/COPD
☐ Cardiovascular disease
☐ Venous stasis disease
☐ Nonalcoholic fatty liver disease or steatohepatitis
☐ Pseudotumor cerebri / Idiopathic intracranial hypertension
☐ Polycystic ovarian syndrome
☐ Urinary stress incontinence

B. Nicotine status

☐ Never smoker/Never used nicotine
☐ History of nicotine use. Quit Date*: _____
*If quit date < 12 months from time of referral, a negative urine cotinine test is required with referral.

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

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