CENTER FOR WEIGHT MANAGEMENT
HORIZON HEALTH

*** FAX ALL REQUIRED FORMS TO 833-944-2236***

727 East Court Street, Paris, IL 61944
Phone: 217-466-4868

If a patient is experiencing NON-URGENT, ACUTE ISSUES (ex. Inability to eat/drink, persistent nausea/vomiting, abdominal pain) RELATED TO A PRIOR BARIATRIC SURGERY, DO NO USE THIS form. REFER DIRECTLY to Horizon Health Center for Weight Management. Phone 217-466-4033. Visit our website: https://www.myhorizonhealth.org/services/center-for-weight-management for more information.

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|---|---|---|
| PATIENT NAME: | DOB: | AGE: |
| REFERRING PROVIDER: | REFERRAL DATE | WEIGHT(lbs) + DATE OBTAINED: |
| PCP (if different from referring provider) | HEIGHT: ft. in. | BMI: |
| INSURANCE: | INSURANCE MEMBER ID: | INSURANCE GROUP #: |
| PREFERRED PATIENT PHARMACY: | | |

ALL REFERRALS MUST BE ACCOMPANIED BY:

- ☐ Completed referral form **AND** most recent FULL history
- ☐ Patient detailed demographics sheet **AND** copy of current insurance card
- ☐ Patient problem list **AND** current medication list
- ☐ Additional documentation as indicated based on reason for referral (see below)

## SECTION 1: REASON FOR REFERRAL

| ☐ **Patient with NO history of bariatric surgery** | ☐ **Patient HAS history of bariatric surgery** |
|---|---|
| **Additional documentation for bariatric evaluation**<br>☐ Completed section 1 & 2 of this form<br>☐ Recent chart note (within last 6 months) documenting obesity diagnosis AND patient interest in bariatric surgery | **Additional documentation for establishing care:**<br>☐ Operative Report<br>Procedure Type: _____<br>Procedure Date: _____<br>Location: _____ Surgeon: _____<br>☐ Re-establish routine post-operative care<br>☐ Seeking revision/conversion of a prior bariatric surgery<br>Reason_____ |

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

- ☐ AGE REQUIREMENT: 18-65 YEARS
- ☐ BMI >35 WITH CO-MORBIDITY
- ☐ BMI >40
- ☐ NO PSYCHIATRIC HOSPITALIZATIONS IN THE PAST YEAR

## SECTION 3: ADDITIONAL INFORMATION

A. Presence of Obesity-Related Condition: Mark all that apply:

- ☐ Diabetes mellitus -Type 1 or 2
- ☐ Hypertension
- ☐ Sleep apnea
- ☐ Arthritis/degenerative joint disease in major weight bearing joints
- ☐ Gastroesophageal reflux disease
- ☐ Hyperlipidemia
- ☐ Asthma/COPD
- ☐ Cardiovascular Disease
- ☐ Venous stasis disease
- ☐ Nonalcoholic fatty liver disease or steatohepatitis/NASH
- ☐ **PATIENT HAS NO CO-MORBIDITIES**

B. NICOTINE STATUS (ALL FORMS) –

- ☐ NEVER USED NICOTINE
- ☐ CURRENT NICOTINE USER: YEARS_____ IS PATIENT WILLING TO QUIT: YES_____ NO_____
- ☐ FORMER NICOTINE USER: QUIT DATE: _____

Referring provider signature: _____ Date:_____

Provider Address: _____ Provider Phone Number:_____