330 Turner McCall Blvd.
Suite 202
Rome, GA 30165
Phone 706-509-5122
Fax 706-292-7364
www.floydbariatrics.org

Letter of Referral for Weight Loss Surgery

Patient Name: _____ DOB: _____

The patient named above is a patient of mine with a longstanding history of obesity that has been refractory to medical weight loss regimens. The patient's obesity related comorbidities include:

❑ Diabetes ❑Hypertension ❑Sleep Apnea

Other:_____
_____
_____

The patient's additional medical history is significant for:

_____
_____
_____

The patient's most recently recorded height and weight:
Height: _____ Weight: _____ BMI: _____ Date: _____

My patient is motivated to make lifestyle changes required to maximize the likelihood of successful, sustained weight loss and would therefore benefit from weight loss surgery in order to improve their overall health, quality of life, and to minimize their risk of obesity related comorbidities. In my opinion, weight loss surgery for this patient is medically necessary to treat the above comorbidities.

Please evaluate my patient as a candidate for weight loss surgery.
If considered an appropriate candidate:

- ❑ The patient has been evaluated and deemed medically optimal to proceed with surgery
- ❑ I will need to see the patient back again in the office for formal pre-operative clearance

Physicians Signature: _____ Date: _____

I have also enclosed documentation of prior weight loss efforts and the patient's weights at our office.

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Physician Supervised Weight Loss Visit

Patient Name: _____ Date: _____
DOB: _____ Physician: _____

WT: _____ HT: _____ BP: _____ Pulse: _____ TEMP: _____

Diagnosis: 1) _Obesity (E66.01)___ 2) _____ 3) _____
4) _____ 5) _____ 6) _____

Current Dietary Program:
☐ Low Fat ☐ Weight Watchers ☐ Atkins ☐ South Beach ☐ Thrive ☐ Diabetic Diet ☐ Dietitian ☐ Other

_____

Physical Activity/Exercise Program:
☐ Increased daily physical activity ☐ Target HR 3x/week ☐ Walking ☐ Gym Attendance ☐ Other

_____

Behavioral Interventions:
☐Meeting with dietitian ☐ Food journaling ☐ Support group ☐ www.fitday.com ☐ Other

_____

Consideration or use of Pharmacotherapy w/FDA approved medication:
☐Pharmacotherapy contraindicated secondary to medical condition

_____
_____

Addition Comments and/or recommendations:

_____
_____

Signature_____