

**Weight Wise Tertiary Clinic Referral – Adult 17+**

**Mandatory Data Required for Processing Referral**  
(missing or incomplete information will delay processing)

- Patient Name and Demographics
- Referring and Family Physician Information
- Eligibility Criteria Information

*Place patient label here*

**If the Patient has had prior Bariatric Surgery elsewhere - DO NOT use this form. Complete Referral to Bariatric Surgeon for Bariatric Surgery Completed Elsewhere**

**Patient Demographics** *(Please print clearly)*

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_  
 Street address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Mailing address (if different) \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Phone number (day) \_\_\_\_\_ Phone number (after hours) \_\_\_\_\_  
 PHN / ULI \_\_\_\_\_ Gender  M  F Date of birth (d/m/y) \_\_\_\_\_  
 Care contact person (specify relationship) \_\_\_\_\_ Contact number \_\_\_\_\_

**Referring Physician**

Name \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 PRACID # \_\_\_\_\_

**Family Physician** *(If different than Referring Physician)*

Name \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 PCN \_\_\_\_\_

**Specialists / Consultants involved in patient's care**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_

**Eligibility Criteria** *(Patients must meet all criteria to be eligible for admission to the clinic)*

**BMI ≥ 35 kg/m2**     **EOSS (Edmonton Obesity Staging System) Stage 2, 3, or 4**     **Prior Treatment Completed**

<b>BMI</b> _____ kg/m2 <b>Current Weight</b> _____ kg OR _____ lbs <input type="checkbox"/> measured <input type="checkbox"/> reported <b>Current Height</b> _____ cm OR _____ in <input type="checkbox"/> measured <input type="checkbox"/> reported	<b>EOSS (Edmonton Obesity Staging System)</b> <i>(Check stage that applies to patient)</i> <input type="checkbox"/> <b>STAGE 2</b> <input type="checkbox"/> <b>STAGE 3</b> <input type="checkbox"/> <b>STAGE 4</b>
<b>Prior Treatment Completed</b> <i>(All areas must be checked prior to submission of this form)</i> <input type="checkbox"/> Patient DOES NOT have UNTREATED severe personality disorder, active psychosis, active substance dependencies, and/or major cognitive impairment. <input type="checkbox"/> Patient has the ability to attend a MINIMUM of 10 Clinic appointments in a 9 month period. <input type="checkbox"/> Patient has completed a MINIMUM of 6 months PRIMARY CARE weight management intervention including: <ul style="list-style-type: none"> <li><input type="checkbox"/> Completion of Weight Wise Education Modules <i>(Minimum 4 mandatory - Module One plus any 3 other modules)</i></li> <li><input type="checkbox"/> Lifestyle journaling including daily food journal</li> <li><input type="checkbox"/> Nutritional counseling</li> <li><input type="checkbox"/> Patient using pedometer and physical activity / walking program initiated</li> <li><input type="checkbox"/> Primary Care mental health screening completed and treatment initiated as required</li> </ul>	
<b>Additional Treatment</b> <i>(The following are not mandatory)</i> <input type="checkbox"/> Bariatric pharmacological intervention initiated in last 6 months <input type="checkbox"/> Initiation of smoking cessation program <i>(For Bariatric surgery consideration, minimum 3 months smoking cessation required)</i>	

**Special Requirements**

Patient is unable to participate in group treatment options *(Please describe)* \_\_\_\_\_  
 Hearing, visual impairment *(Please specify)* \_\_\_\_\_  
 Activity [Mobility] limitations, requires oxygen, etc *(Please specify)* \_\_\_\_\_  
 Unable to read or speak English *(Please specify language)* \_\_\_\_\_  
 Translator/contact person \_\_\_\_\_ Phone number \_\_\_\_\_