Alberta Health Services

Affix patient label within this box.

Prior Bariatric Surgery Referral

Fax completed form along with all required information to **780.735.6669**

- **Only complete for patients who have had prior bariatric surgery completed elsewhere requiring possible revision**
- **Not to be used for laparoscopic gastric band (LABG) fills or routine follow up appointments**
- Please allow adequate time for organizing investigations and referral
- For all inquiries please contact on behalf of your patient
- If urgent/emergent conditions arise please have patients report to their nearest Emergency Department

Patient Demographics		
Name *(last, first)*		
Address	City	Postal Code
Home phone	Alternate phone	
Personal Health Care Number *(PHN)*	Gender ☐ Male ☐ Female	Date of birth *(yyyy-Mon-dd)*
Care contact name	Relationship to patient	Phone

Referring Source		
Name		
Phone	Fax	PRACID No.

Family Physician *(if different from referring source)*		
Name		
Phone	Fax	PRACID No.

Mandatory Data *(incomplete referrals will not be processed)*

☐ Referral letter from referring physician

☐ Primary reason for referral _____

☐ Recent blood work *(less than two months old) CBC and differential, Ferritin, Vit B12 and D3, Glucose fasting, Electrolytes, Creatinine, Calcium, Phosphate, Magnesium, Total protein, Albumin, Liver panel (ALK phos, ALT, total bilirubin), LDL cholesterol, HDL cholesterol, Tryglycerides, Total cholesterol, PTH calcium, 25-OH Vit D3*

☐ Barium stomach and duodenum (S&D)
(submit hard copy to Room 137 CSC, 10240 Kingsway Ave. Edmonton, AB T5H 3V9)

☐ Location of surgery _____ Date *(yyyy-Mon-dd)* _____

☐ Surgical procedure *(choose one)*

☐ Vertical Gastric Banding ☐ Open ☐ Gastric Bypass ☐ Sleeve Gastrectomy

☐ Laparoscopic ☐ Laparoscopic Adjustable Gastric Banding (LABG)

☐ Other _____

☐ Bariatric Surgical Report *(if available)* and/or surgeon name _____