| Last Name | |
|---|---|
| First Name | |
| Birthdate *(yyyy-Mon-dd)* | PHN# |

## Prior Bariatric Surgery Referral

Fax completed form along with all required information to

☐ Edmonton **780.735.4866** ☐ Calgary **403.955.8634**

- **Only complete for patients who have had prior bariatric surgery**
- **Patients must be aware that they will be assessed by a multidisciplinary team to determine their best plan of care**
- 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<br>☐ Male<br>☐ 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)*

☐ Primary reason for referral ______________________________

☐ 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 ______________________________