

Edmonton Adult Bariatric Specialty Clinic Referral

Please Fax completed form to Alberta Health Services Central Access at **780.735.3553** or Toll Free (Alberta only) at **1.866.979.3553** OR Call for booking 780.401.2665.

Affix patient label within this box

If patient has had a Bariatric Surgery, Do Not use this form. Instead, complete **“Prior Bariatric Surgery Referral”**
Missing or incomplete information will delay processing.

Patient Demographics <i>(Please print clearly)</i>			
Name <i>(last, first, middle)</i>			
Street address		City	Postal Code
Mailing address <i>(if different)</i>		City	Postal Code
Phone number <i>(day)</i>		Phone number <i>(after hours)</i>	
Personal Health Number/Unique Lifetime Identifier		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth <i>(yyyy-Mon-dd)</i>
Referring Physician / Nurse Practitioner (NP)		Primary Care Physician / NP <i>(If different than Referring Provider)</i>	
Name		Name	
Phone number		Phone number	
Fax number		Fax number	
Practitioner Identification Number		Practitioner Identification Number	
Primary Care Network (PCN)		Primary Care Network (PCN)	
Referral Criteria <i>(check all that apply)</i>			
<input type="checkbox"/> BMI greater than or equal to 40 OR <input type="checkbox"/> BMI greater than or equal to 35 with any weight-related co-morbidity such as cardiovascular disease, type 2 diabetes mellitus, sleep apnea, gall bladder disease, osteoarthritis, hypertension and/ or chronic pain. <input type="checkbox"/> Resident of Alberta <input type="checkbox"/> Non Smoker <input type="checkbox"/> Age 17-64 years old at time of referral			
Please list all comorbidities and provide any relevant documentation <i>(test results, reports, etc.)</i>			
Current BMI _____ kg/m ²		Highest Recorded Weight _____ kg or lb Date <i>(yyyy-Mon-dd)</i> _____	
Current Weight _____ kg or _____ lb		Date <i>(yyyy-Mon-dd)</i> _____ <input type="checkbox"/> measured <input type="checkbox"/> reported	
Current Height _____ cm or _____ in		Date <i>(yyyy-Mon-dd)</i> _____ <input type="checkbox"/> measured <input type="checkbox"/> reported	
Does patient have significant mental health issues <i>(severe personality disorder, active psychosis, active substance dependencies, recent suicide ideation or attempt in the past 6 months)</i> or major cognitive or psychosocial issues that could be a barrier to lifestyle/behaviour changes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Supporting Documents			
Include relevant documentation that may inform Bariatric Assessment such as blood work, diagnostic imaging, consultant letters, discharge summaries, medications.			