



Fax – New Patient Referral Form

Attention: _____ From: _____
 Fax number: 574-537-1034 Today's Date: _____
 Total pages, including cover: _____ Phone number: _____

Please complete this form and fax . **All new patients are required to attend a free new patient informational seminar.** Team:Bariatrics will contact the patient to schedule the seminar. The initial consultative appointment will be scheduled at the seminar. This ensures patient understanding and commitment to the lifestyle changes needed to be successful in the Team:Bariatrics programs. **Please fill out completely for your patient to receive the best service.**

PATIENT INFORMATION:

Patient Name: _____ DOB: _____
 Address: _____ SSN: _____ - _____ - _____
 City: _____ State: _____ ZIP: _____
 Home #: _____ Cell #: _____
 Primary Insurance: _____ Secondary Insurance: _____
 ID#: _____ Group #: _____ ID#: _____ Group #: _____
 Provider Services Phone #: _____ Provider Services Phone #: _____

Reason for Referral: _____

PATIENT HEALTH HISTORY:

Height: _____ Weight: _____ BMI: _____

Medical History/Co-morbidities (please check all that apply):
 Acid Reflux (GERD) Arthritis
 Diabetes – Type 1 Diabetes – Type 2 High Cholesterol Hypertension Obstructive Sleep Apnea

Other (please describe any other medically relevant conditions): _____

PROVIDER INFORMATION:

Referring provider: _____ Form completed by: _____
 Referring provider fax #: _____