

Bariatric Surgery Program Metabolic Obesity Program

Basic information

Patient last name: _____ First: _____ Middle: _____

Mr. Mrs. Miss Ms. **New patient to Cook Children's?** Yes No

DOB: _____ Age: _____ (must be between 11-18 years old) Sex: M F

Address: _____

Is the patient a minor? Yes No If so, please complete with parent information.

Contact number(s): _____ Cell: _____ Home: _____

Email: _____

Language: _____ Will an interpreter be needed? Yes No

Insurance information

Please also submit a copy of the patient's insurance card with this completed referral form.

Is the patient covered by insurance? Yes No **Primary insurance (HMO/PPO/POS):** _____

Is there secondary insurance? Yes No **Subscriber's name:** _____

Patient's relationship to the subscriber: Self Spouse Child Other

Clinical information

Patient last name: _____ First: _____ Middle: _____

Height: _____ Weight: _____ BMI: _____

Tried weight loss programs before? Yes No **Weight loss programs tried?** _____

Does the patient meet the criteria of either BMI option below?

BMI greater than or equal to 35 with a comorbidity BMI greater than or equal to 40 with no comorbidity

Select all comorbidities that apply:

Arthritis Diabetes type 2 Dyslipidemia Hyperinsulinism/insulin resistance Hypertension NAFLD/NASH
 Polycystic ovary syndrome Sleep apnea Slipped capital femoral epiphysis

Select all that apply:

Abdominal pain Acanthosis nigricans Amenorrhea Anxiety Bulimia/other eating disorders Chronic fatigue
 Depression Dizziness Dysmenorrhea Headaches Irregular menses Menorrhagia Mood swings
 Sexually transmitted diseases Vomiting

The primary reason for referral: _____

Referring physician: _____ Phone: _____ Fax: _____

Physician signature: _____ Date/time: _____

Please fax this form with supporting clinical information to 682-303-4242.