CAPE FEAR VALLEY HEALTH

Bariatric Weight Loss Program

Letter of Referral for Weight Loss Surgery

Patient Name ____ DOB ______________________

The patient named above is a patient of mine with a longstanding history of obesity that has been refractory to medical weight loss regiments. The patient's obesity related comorbidities include:

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The patient's additional medical history is significant for:

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The patient's most recently recorded height and weight:

Height: _____________ Weight: _____________ BMI: _____________ Date: _____________

My patient is motivated to make lifestyle changes required to maximize the likelihood of successful, sustained weight loss and would therefore benefit from consideration for weight loss surgery in order to improve their overall health, quality of life, and to minimize their risk of obesity related comorbidities.

Please evaluate my patient as a candidate for weight loss surgery. If considered an appropriate candidate:

___ The patient is medically cleared for surgery

___ I will need to see the patient back in the office for formal pre-operative clearance

Physician's Signature ____ Date ______________________

I have also enclosed documentation of prior weight loss efforts and the patient's weights at our office.