The Surgical Weight Loss Program for Teens
Bariatric Referral Form

Dear Doctor,
Thank you for your kind referral to the Surgical Weight Loss Program for Teens at Cincinnati Children's Hospital Medical Center. To begin our evaluation process please complete this form and return it to **Penni Taylor, Customer Service Representative**, using one of the 3 methods listed below. Call **513-636-9215** with any questions regarding this form.

1. Email: penni.taylor@cchmc.org
2. Fax: 513-636-7657
3. Mail: Surgical Weight Loss Program for Teens
   Cincinnati Children's Hospital Medical Center
   Mail Location 2023
   3333 Burnet Avenue
   Cincinnati, OH 45229-3039

Patient Name: _____ **DOB:** _____

Parent/Guardian Name: _____

Address: _____

Phone: _____ Email: _____

Referring Clinician: _____ Primary Specialty: _____

Address _____

Phone: _____ Fax: _____ Email: _____

How long have you been treating this patient? _____

Date of last appointment: _____ **Height (inches):** _____ **Weight (pounds):** _____

Primary Insurance Carrier: _____ **ID Number:** _____

Insurance Phone & Contact: _____

**** Please send a copy of the patient's insurance card along with the completed referral form***

Current Co-morbidities (check all that apply):

- ☐ Diabetes
- ☐ Abnormal lipid panel
- ☐ Hypertension
- ☐ Sleep Apnea
- ☐ Insulin Resistance
- ☐ Depression
- ☐ Heart Disease
- ☐ Fatty Liver Disease
- ☐ Menstrual Changes
- ☐ Joint Pain
- ☐ Pseudotumor Cerebri
- ☐ Stress Urinary Incontinence
- ☐ Polycystic Ovary Syndrome
- ☐ Impaired ADLs
- ☐ Heartburn
- ☐ Asthma
- ☐ Gallstones
- ☐ Soft Tissue Infections

Primary reason for referral: _____

_____

_____

Important Note: It would be helpful to enclose clinic notes (weight management or dieting attempts), documentation of co-morbidities, prior surgery recent lab results, sleep study report, oral glucose tolerance test results, copies of consultant reports, growth chart.

Your signature below indicates that you are requesting that we evaluate your patient for bariatric surgery due to unsuccessful non-operative weight loss attempts. Feel free to call **513-636-4453** if you have any other information which might be helpful for our evaluation of this patient or if you have any questions or concerns

Signature: _____ Date: _____