Cincinnati Children's

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 **Cassandra McDaniel** using one of the 3 methods listed below. Call **513-636-4453** with any questions regarding this form.

1. Email: cassandra.mcdaniel@cchmc.org
2. Fax: 513-487-5568
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: