



Name: \_\_\_\_\_

DOB: \_\_\_\_\_

MRN: \_\_\_\_\_

Website: [www.cincinnatichildrens.org/service/s/weight-loss](http://www.cincinnatichildrens.org/service/s/weight-loss)

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 using one of the two methods listed below. Call **513-517-1150** with any questions regarding this form.

1. Fax: 513-487-5568
2. 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/Primary Caregiver 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*

<b>Current Co-morbidities (check all that apply):</b>		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Polycystic Ovary Syndrome
<input type="checkbox"/> Abnormal lipid panel	<input type="checkbox"/> Fatty Liver Disease	<input type="checkbox"/> Impaired ADLs
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Menstrual Changes	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Asthma
<input type="checkbox"/> Insulin Resistance	<input type="checkbox"/> Pseudotumor Cerebri	<input type="checkbox"/> Gallstones
<input type="checkbox"/> Depression	<input type="checkbox"/> Stress Urinary Incontinence	<input type="checkbox"/> Soft Tissue Infections
<b>Primary reason for referral:</b>		

**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/Credentials

Printed Name

Date

