Saskatchewan Health Authority

Saskatchewan Bariatric Surgical Program Patient Referral Form

Height __________cm Weight __________kg

BMI ______________

Name:

Mailing address:

Phone number:

DOB:

HSN:

Program Criteria – Please ensure patient meets ALL below criteria

- ☐ BMI 35 or greater
- ☐ Resident of Saskatchewan
- ☐ Non – smoker
- ☐ 18 years of age or older
- ☐ Previous weight loss attempts
- ☐ No active substance abuse
- ☐ Medically stable to participate in physical activity

Health History

☐ Hypertension	☐ Sleep Apnea	☐ Respiratory Disease - Describe: ________________________
☐ Coronary Artery Disease	☐ Chronic Pain	☐ GI (GERD, Crohn's, Colitis): ___________________________
☐ Dyslipidemia	☐ Renal Disease ☐ Hemodialysis	☐ Cancer - Describe: ___________________________________
☐ Liver Disease	☐ Diabetes Mellitus - Type: _________	☐ Arthritis - Describe: _________________________________

☐ Additional Medical History:

☐ Additional Surgical History:

Does the patient have significant mental health issues (severe personality disorder, active psychosis, active substance dependencies, recent suicidal ideation or attempt in the last 6 months) or major cognitive or psychosocial issues that could be a barrier to lifestyle/behaviour changes?

☐ NO ☐ YES – Describe:

List of Medications:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

☐ Cannabis: Type ___________________________________

Supporting Documents

Include relevant documentation that may inform Bariatric Assessment such as blood work, diagnostic imaging, consultant letters, discharge summaries, etc..

Referring Physician/Nurse Practitioner (NP)

Name: ____ Address: ____

Phone Number: _______________________________________ Fax: ____

Physician/NP Signature: _________________________________ Date: ____

Please fax referral to 306-766-7551

Thank you for your referral to the Saskatchewan Bariatric Surgical Program

We will notify you by letter/fax when the patient has been accepted/declined to the program.

Please note that incomplete referral forms will not be returned and/or declined.

For Centre for Metabolic and Bariatric Surgery Date Received: (office use only)

Referring Physician Notified by: ☐ Fax ☐ E-Mail Date: __________________________________

Patient Notified by: ☐ Phone ☐ Mail Date: __________________________________

Date Received: