

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 regimens. The patient's obesity related comorbidities include:

The patient's additional medical history is significant for:

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 again in the office for formal pre-operative clearance

Physicians Signature: _____ Date: _____

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