Atrium Health
Floyd
Center for Bariatric Services

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:

❑ Diabetes ❑Hypertension ❑Sleep Apnea

Other:_____

_____

_____

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 weight loss surgery in order to improve their overall health, quality of life, and to minimize their risk of obesity related comorbidities. In my opinion, weight loss surgery for this patient is medically necessary to treat the above comorbidities.
My patient is able and willing to be compliant with the necessary post - procedural dietary restrictions
Please evaluate my patient as a candidate for weight loss surgery.
If considered an appropriate candidate:

- ❑ The patient has been evaluated and deemed medically optimal to proceed with surgery
- ❑ I will need to see the patient back again in the office for formal pre-operative clearance

Physicians Signature: _____ Date: _____

Phone:706-509-5122
Fax:706-292-7364

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