Highland Hospital
BARIATRIC SURGERY CENTER
1000 South Avenue
Rochester, NY 14620
585-341-0366

Joseph Johsnon, M.D., F.A.C.S.
Maria Durdach, M.D.
Kaci Schiavone, M.D.
Julie Anne Leo, PA-C

Enter any content that you want to repeat, including other content controls. You can also insert this control around table rows in order to repeat parts of a table.

Primary Care Physician Intake Form for Bariatric Surgery

All questions must be complete for insurance submission.

1. Patient Information.

Patient Name: _____ Date of Birth: _____

Height: ____ Last recorded weight was _____lbs., on ___/____/_____ BMI: ___

Morbidly obese for at least 5 years: ☐ YES ☐ NO

Note: *Morbid obesity is defined as either having a BMI greater than or equal to 40 or having a BMI greater than or equal to 35 and an existing documented comorbid condition (diabetes, hypertension, sleep apnea, etc.).*

Is there an endocrinological reason for the obesity? ☐ YES ☐ NO

2. Please document all professionally supervised weight loss attempts.

Program	Year	Number of months the program was followed	Supervised by Doctor (Y/N)	Total weight loss using this program
Weight Watchers				
Jenny Craig				
LA Weight Loss				
Nutri System				
Opti fast				
Medi fast				
Registered Dietitian/ Nutritionist				
Atkins Diet				
Calorie Controlled Diet				
South Beach Diet				
Other				

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Patient Name: _____ **DOB:** _____

3. Patient has the following documented co-morbidities (check all that apply):

☐ Hypertension	☐ Diabetes	☐ Other: _____
☐ Coronary Disease	☐ Pulmonary Disease	_____
☐ Sleep Apnea	☐Degenerative Arthritis	_____

4. Patient has significant disease to any of the following (check all that apply):

☐ Liver Disease	☐ History of DVT/PE
☐ Kidney Disease	☐ Gastrointestinal Disease

5. Current use of tobacco/tobacco products? ☐ YES ☐ NO
   If yes, list # of packs/amount per day: _____
   If patient has quit, list quit date: _____

6. Use of Alcohol? ☐ YES ☐ NO
   If yes, list amounts/frequency: _____
   If a history of alcoholism, list date of abstinence: _____

7. Use of illicit drugs? ☐ YES ☐ NO
   If yes, please list names and frequency: _____
   If there is a history of drug use, list date of abstinence: _____

8. My patient is generally compliant with follow-up appointments, medications, and health care recommendations. ☐ YES ☐ NO

Please attach a list of the patient's current medication regimen.

By signing this form, I, as the patient's primary care doctor, am recommending Bariatric Surgery and am indicating that the patient is medically cleared for surgery.

_____
Printed name of Physician

_____ _____
Signature of Physician Date

All questions must be answered for insurance submission.

PLEASE FAX THIS COMPLETED FORM TO (585) 341-8326

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