

Patient's Name _____ D.O.B. _____

Surgeon _____ Date of Surgery _____

Gastric Bypass Surgery
 Gastric Banding Surgery
 Undecided
 B.M.I. _____

The above named patient is being evaluated for weight loss surgery. The following testing and information is needed as part of our screening and treatment process.

As the patient, you are responsible for arranging any testing or evaluation deemed necessary. Please check with your primary care physician, as well as your insurance company for needed

Test / Procedure / Screening	Referral To:	Required	On Chart
Anesthesia Consult		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiology Consult		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pulmonary Consult		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastroenterology Consult		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gynecology Consult - including recent pap smear, mammography result and pregnancy test		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest X-Ray		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep Study		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electrocardiogram		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
New Patient Seminar Attendance	SCHS 973-989-3644	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clarity MD Completed		<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nutritional Screening	SCHS 973-989-3644	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral Health Screening	SCHS 973-989-3644	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-Operative Support Group Attendance	SCHS 973-989-3644	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Surgeon's H&P		<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lab Testing Schedule through Call One 877-936-1234 <input type="checkbox"/> CBC <input type="checkbox"/> HgbA1c <input type="checkbox"/> Iron Profile <input type="checkbox"/> Fasting Lipid Profile <input type="checkbox"/> Folate <input type="checkbox"/> IGG, H. Pylori, IGM, IGA <input type="checkbox"/> Fasting CMP <input type="checkbox"/> TSH <input type="checkbox"/> Vitamin B 12 Level <input type="checkbox"/> Thiamine Level (frozen specimen)		<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Patient must lose _____ lbs. prior to surgery			
<input type="checkbox"/> Obtain Old Operative Reports			
<input type="checkbox"/> Schedule for IVC (Vena Cava) Filter prior to surgery			

Add to Precert: Ventral Hernia Hiatal Hernia Lysis of Adhesions Other _____

For Hospital Use Only:
 Registered Nurse Signature _____ Date _____
 Anesthesiologist Signature _____ Date _____

Referral Sheet:

Anesthesia

Morris Anesthesia Group
Saint Clare's Hospital
400 W. Blackwell St.
Dover, NJ 07801
973-335-1122

Cardiology

- Patient's own Cardiologist
- _____

Gastroenterology

- Patient's own Gastroenterologist
- _____

Gynecology

- Patient's own Gynecologist
- _____

Pulmonary

- Patient's own Pulmonologist
- _____

Other

- Patient's own Primary Care Physician
- _____
- _____

