Last name:	First name:	M or F
Birthdate:	HSN:	
Address:	**PHONE NUMBER:**	
Height __________(cm)	**Weight_______(kg)**	**BMI______**

Bariatric Surgical Program Patient Referral Form

Program Criteria – (Please ensure patients meet all below criteria)

- ☐ BMI between 40-70 **OR** ☐ BMI between 35-40 with comorbidities (such as sleep apnea, diabetes, hypertension, etc.)
- ☐ Resident of Saskatchewan
- ☐ Non-smoker
- ☐ Age between18-59
- ☐ Previous weight loss attempts
- ☐ No active substance abuse

Past medical history: **Cancer history**: ☐ Not applicable	**Current medications:**
Past surgical history:	**Mental health:** (***please check off to confirm***) ☐ No recent suicide attempts/ideations (last 6 months) ☐ Not experiencing active psychosis or mania **Relevant history:**

Referring physician/Nurse Practioner

Name_____________________________________Address____

Phone number______________________________Fax____

_____________________________ _________________________________

Physician/NP Signature Date

Please fax referral to (306)766-7551
Thank you for your referral to the 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 be returned/and or declined.