

## Surgical Weight Loss Institute Physician Referral Letter

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Email: \_\_\_\_\_

Street Address:  
(mandatory) \_\_\_\_\_

P.O. Box (optional for mailing only) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tel. No-HM: \_\_\_\_\_ WK: \_\_\_\_\_ CEL: \_\_\_\_\_

**Insurances accepted: HMSA, UHA, DMBA, HMA/Summerlin, MDX & Cash**

Medical Insurance: \_\_\_\_\_ Primary Ins Policy #: \_\_\_\_\_

Secondary Ins/Policy #: \_\_\_\_\_

**HMO** (PCP send referral letter to HMSA)  **PPO**

Please calculate height and weight in metric using the following web link:

<http://www.medcalc.com/body.html>

Height in centimeters: \_\_\_\_\_ Weight in kilograms: \_\_\_\_\_ BMI: \_\_\_\_\_

***ONLY if Available, Please Attach All Pertinent Medical Records that address the following questions:***

1. Has patient been medically cleared for all co-morbidities?
2. Has patient been evaluated for hypothyroidism or other endocrinopathology?
3. Has patient received cardiac clearance for surgery?
4. Has patient had an evaluation and/or for h. pylori if patient was symptomatic for Gerd or gastric reflux?
5. Has patient completed a physician supervised diet with monthly weigh-ins?
6. Has patient completed a supervised exercise program?

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_  
Signature of Referring Physician

\_\_\_\_\_  
Date

**Fax Completed Referral to SWLI office: (808) 263-5309**