Kaleida Health

DOWNTIME ☐ Entered into electronic record after downtime

date time

initials

Patient Name

Date of Birth Admission/Visit Date Site

Medical Record Number Financial Number

Patient ID Area

BARIATRIC APPLICATION PACKET

PRIMARY CARE PHYSICIAN REFERRAL

This page to be completed by Referring Primary Care Physician.

The Center for Minimally Invasive Surgery
Kaleida Health-Buffalo General Hospital
100 High Street, Buffalo, NY 14203
716-859-1168 (Office)
716-859-2067 (Application office)
716-859-3352 (Fax)

RE:
DOB:

Dear Dr's Posner, Hoffman and Butsch,

I am referring _____ to be considered for weight loss surgery for obesity. This patient has been under my care for the past _____ years. Despite numerous attempts, _____ remains obese. The patient currently weighs _____ pounds and is _____ feet and _____ inches, which calculates to a Body Mass Index (BMI) of _____. During the past five years the patient's weight has been documented as follows:

Year	Weight
23	

The patient's co-morbidities include:_____

_____.

_____ has tried many diets and exercise programs including:

_____

_____.

These diets and exercise programs were medically approved and supervised.

The patient's most recent TSH level is _____ and was last tested _____.

She/He is currently taking the following medications:

_____.

In the past, I have treated her/him for the following medical conditions, with the following results:

_____

_____.

I am currently treating this patient for:

_____

_____.

I have confidently ruled out other causes of obesity and can be contacted at _____ if you have any questions.

_____ _____ _____

Physicians Signature Required Date Time