



# Kaleida Health

## PRIMARY CARE PHYSICIAN LETTER OF SUPPORT

Patient ID Area

### This page to be completed by Referring Primary Care Physician

The Center for Minimally Invasive Surgery  
Kaleida Health-Buffalo General Medical Center  
100 High Street, Buffalo, NY 14203  
716-859-1168 (Office)  
716-859-2067 (Application office)  
716-859-4715 (Fax)

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

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, he/she 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

This patient has been diagnosed with the following medical conditions:

- Diabetes     Hypertension     Sleep Apnea     Joint Pain (*site*) \_\_\_\_\_
- Other weight-related conditions include \_\_\_\_\_

The patient has utilized the following weight loss attempts:

- Weight Watchers     Jenny Craig     Nutrisystem     Slim-Fast
- Other therapies \_\_\_\_\_

These diets and exercise programs were medically approved and supervised.

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

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

Physicians Signature Required \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Print Name \_\_\_\_\_