Saskatchewan Health Authority

Saskatchewan Bariatric Surgical Program
Patient Referral Form

Height _____cm Weight _____kg

BMI _____

Name:

Mailing address:

Phone number:

DOB:

HSN:

Program Criteria – Please ensure patient meets ALL below criteria

☐ BMI between 40 – 70 **OR** BMI between 35 – 40 with comorbidities (i.e. sleep apnea, diabetes, hypertension, etc.)

☐ Resident of Saskatchewan
☐ Non – smoker
☐ Must be 18 years of age or older
☐ Previous weight loss attempts
☐ No active substance abuse
☐ Medically stable to participate in physical activity

Health History

☐ Hypertension	☐ Sleep Apnea	☐ Respiratory Disease - Describe: _____
☐ Coronary Artery Disease	☐ Chronic Pain	☐ GI (GERD, Crohn's, Colitis): _____
☐ Dyslipidemia	☐ Renal Disease ☐ Hemodialysis	☐ Cancer - Describe: _____
☐ Liver Disease	☐ Diabetes Mellitus - Type: _____	☐ Arthritis - Describe: _____

☐ Additional Medical History:

☐ Additional Surgical History:

Does the patient have significant mental health issues (severe personality disorder, active psychosis, active substance dependencies, recent suicidal ideation or attempt in the last 6 months) or major cognitive or psychosocial issues that could be a barrier to lifestyle/behaviour changes?

☐ NO ☐ YES – Describe:

List of Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

☐ Cannabis: Type _____

Supporting Documents

Include relevant documentation that may inform Bariatric Assessment such as blood work, diagnostic imaging, consultant letters, discharge summaries, etc..

Referring Physician/Nurse Practitioner (NP)

Name: _____ Address: _____

Phone Number: _____ Fax: _____

Physician/NP Signature: _____ Date: _____

Please fax referral to (306) 766 – 7551

Thank you for your referral to the Saskatchewan 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 not be returned and/or declined.

For Centre for Metabolic and Bariatric Surgery Date Received: (office use only)

Referring Physician Notified by: ☐ Fax ☐ E-Mail Date: _____

Patient Notified by: ☐ Phone ☐ Mail Date: _____

Date Received: