



Bariatric Surgery Assessment Form: Patient Referral Information

Demographic Information

Primary Care Physician _____ Date of Request _____
Address _____ Phone Number _____
_____ NPI _____

Patient Name _____ BCN Contract Number _____
Address _____ Phone Number _____
_____ Date of Birth _____

Sex: Male Female • Height: _____ • Weight: _____ lbs. • BMI _____

Comorbidities (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Atherosclerotic heart disease | <input type="checkbox"/> Hypertension | List other(s):

_____ |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Sleep apnea | |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Degenerative joint disease | <input type="checkbox"/> Type 2 diabetes | |
| <input type="checkbox"/> Hyperlipidemia | | |
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Fax the following information to BCN at 1-800-675-7278:

1. Completed *Physician-Supervised Weight Loss Program Documentation* forms or other documentation that has been completed during physician-supervised office visits for six consecutive months over the last four years.
2. Information from a psychological evaluation that has been performed as a presurgical assessment. Providers should call the BCN Care Management department at 1-800-392-2512 to request a referral for the psychological evaluation.
3. Name of the bariatric surgery facility at which the initial consultation is to be performed:
Note: Individuals with Medicare coverage must select a facility that is approved by the Centers for Medicare & Medicaid Services. For BCN Advantage members, the facility must also be affiliated with BCN Advantage.

4. Name of the referral surgeon: _____

5. This form, completed and signed below by the physician.

I have discussed this procedure with my patient and we both have a good understanding of the risks involved and reasonable expectations that the patient will be compliant with all postsurgical requirements.

Physician Signature

Date