Referral Guidelines

Patient name: ______________________________ Patient age/DOB: ______________

Caregiver name/relationship: ______________________________ Caregiver phone: ______________

Caregiver Address: ______________________ City: ______________ State: ______ Zip: ________

Primary language: ______________________ Referring provider (PCP): ______________________

Height: ________ Weight: ________ BMI: __________

Reason for referral: ____

Areas of most concern

❒ Rate of weight gain ____

❒ BMI ____

❒ Family history ____

❒ Liver/ALT ____

❒ Lipids (specific) ____

❒ Blood pressure ____

❒ Diabetes (Glucose/Hgb A1C) ____

❒ Irregular menses ____

❒ Sleep/OSA ____

❒ Joint problems ____

❒ Psych (depression, anxiety, family stressors, eating disorder) ______________________

❒ Other ____

Please attach

❒ Relevant lab work (clarify fasting or non fasting) - Lipids, Glucose, Hemoglobin A1c, AST/ALT

❒ Growth chart, including BMI chart

❒ Summary of motivation of family

❒ What has been done in primary care clinic or community?

Contact the Bariatric Surgery Center

Children's Hospital Colorado complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. • ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-720-777-1234. • CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-720-777-1234.

WTMGT-140120-2018-09