ST. LOUIS BARIATRIC
SPECIALISTS, LLC
A New Tool, A New Life.

PRIMARY CARE PHYSICAN REQUEST FORM

Dear Darin Minkin
I am referring my patient_____ date of birth_____,
to you for your opinion regarding the possibility of weight loss options, including surgery. The patient's current weight is_____, height is_____, BMI is_____. The patient has been morbidly obese for _____, years

The patient five (5) year weight history
(1) Yr:_____ Wt:_____ (2) Yr_____ Wt:_____ (3) Yr:_____ Wt:_____
(4) Yr:_____ Wt:_____ (5) Yr:_____ Wt:_____

The patient suffers from the following co-morbid conditions associated with morbid obesity which include (Please check all the apply)

Type 2 diabetes – controlled by oral medications
Type 2 diabetes – controlled by injectable medications
Obstructive sleep apnea
Valvular heart disease
Hypertension
Dyslipidemia
Stress incontinence
GERD
Heart burn
Arthritis
History of medical non-compliance

The patient also has the following conditions that are associated with morbid obesity

The patient's previous weight loss attempts

TSH Required. Other tests listed optional, please provide results if applicable.

Laboratory testing such as lipid, HGB A1C,TSH (Required)
Sleep Study
Exercise stress test

Pulmonary function test
Venous duplex
Other:_____

This patient has attempted other weight reduction alternatives and has been unsuccessful in maintaining adequate weight loss. Please render your opinion on appropriate management options.

Sincerely,

_____ _____ _____
Signature (Required) Date Phone

_____ _____
Printed Name Address (Required)

2355 Dougherty Ferry Road | Suite 430 | St. Louis Missouri 63122
P: 314-965-8410 | F: 314-965-8756 | www.stllapband.com