ONTARIO BARIATRIC PROGRAMS REFERRAL FORM

PLEASE NOTE: All referrals to Ontario Bariatric Programs are to be submitted via the online referral web portal. This worksheet has been provided for reference purposes only and will help you and your office to submit a referral using the online referral web portal. As such, it is not a valid referral form.

The following sections/fields (*) are **required**.

PATIENT INFORMATION FOR REFERRAL* (PLEASE PRINT CLEARLY)

Date of Birth (YYYY-MM-DD): *

Ontario Health Card Number: * **Version Code:**

☐ My patient is a resident of Ontario but does not have an Ontario Health Card. My patient (select one of the following health program options only):
- ☐ Is a member of the Canadian Armed Forces (CAF) and has health coverage under the Military Health Care Plan
- ☐ Is a member of the Royal Canadian Mounted Police (RCMP) and has health coverage under the Federal Public Service Health Care Plan
- ☐ Is a Status Indian and has health coverage under Health Canada's First Nation and Inuit Health Program
- ☐ Is a refugee and has health coverage under the Interim Federal Health Program (IFHP)
- ☐ Has other health coverage through another program not listed above

Please Note: If your patient has provincial or federal health care coverage that is not listed above, please contact Technical Support at BariatricReferral.TechSupport@phri.ca for further assistance. Do not send any personal health information (e.g. patient name, health card number) via email or other unsecured means.

Sex: * ☐ Male ☐ Female

TO CALCULATE BODY MASS INDEX (BMI)* (PLEASE PRINT CLEARLY)

Height: *		☐	cm	**Weight: ***		☐	kg
		☐	inches			☐	Lbs.

ELIGIBILITY QUESTIONS: *

1.	Has your patient had previous bariatric surgery?	☐	No	☐	Yes
a.	If Yes, was the previous bariatric surgery performed at a private clinic?	☐	No	☐	Yes
b.	If No, when was the previous surgery was performed:				
☐	i. More than 5 years ago				
☐	ii. Less than 5 years ago				
☐	iii. Unknown				
c.	If >5 Years or Unknown, my patient is now seeking				
☐	i. Management of weight regain *(My patient experienced a 15% increase total body weight from surgery to 15 months post- op. Please note: your patient will be assessed for eligibility at the Bariatric Centre of Excellence)*				
☐	ii. Follow-up care for surgical complications and/or medical issues				
2.	Does your patient have an active drug and/or alcohol addiction?	☐	No	☐	Yes
3.	Is your patient currently undergoing active treatment for a recent major/life-threatening, cancer (e.g., chemotherapy, radiation)?	☐	No	☐	Yes
4.	Does your patient have any significant psychiatric illness that is inadequately treated?	☐	No	☐	Yes
5.	Does your patient currently smoke? (e.g., cigarettes, e-cigarettes, cigars)?	☐	No	☐	Yes
6.	Does your patient have Idiopathic intracranial hypertension?	☐	No	☐	Yes
7.	Does your patient have any of the following comorbidities?	☐	No	☐	Yes
a.	Coronary heart disease	☐	No	☐	Yes
b.	Type 2 diabetes	☐	No	☐	Yes
c.	Hypertension	☐	No	☐	Yes
d.	Diagnosed sleep apnea	☐	No	☐	Yes
e.	Gastroesophageal reflux disease (GERD)	☐	No	☐	Yes
f.	Renal disease	☐	No	☐	Yes

PROGRAM ALLOCATION*

Please refer my patient to the (please select **ONLY** one):

- ☐ Bariatric Medical Program
- ☐ Bariatric Surgical Program
- ☐ Pilot Metabolic Surgical Program at St. Joseph's Healthcare Hamilton
  - ☐ My patient is aware that he/she will need to assume the cost of travel and accommodation arrangements and expenses

PRIMARY CARE PROVIDER INFORMATION*

Are you the patient's Primary Care Provider?	☐	No	☐	Yes

PATIENT CONTACT INFORMATION (PLEASE PRINT CLEARLY)

First Name * | **Last/Family Name ***

Address *

ON – Ontario

City * | **Province** | **Postal Code ***

( ) | ( )

Primary Phone Number * | **Ext.** | **Secondary Phone Number** | **Ext.**

Type * ☐ Home ☐ Mobile ☐ Work **Type** ☐ Home ☐ Mobile ☐ Work

Email Address

PLEASE NOTE: If you have not already registered to submit referrals via the online referral portal, the following information is required for registration.

The following sections/fields (*) are **required**.

REFERRING HEALTHCARE PROVIDER INFORMATION (PLEASE PRINT CLEARLY)

Title * ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Prof. ☐ Ms. ☐ Miss.

OHIP Billing Number (6-digits)*

First Name * | **Last/Family Name ***

Office/Clinic Name | **Office/Clinic Address***

ON – Ontario

City * | **Province** | **Postal Code ***

( ) | ( )

Office/Clinic Phone Number * | **Ext.** | **Secondary Office/Clinic Phone Number** | **Ext.**

( ) | ( )

Office/Clinic Fax Number * | **Secondary Office/Clinic Fax Number**

Email Address

- ☐ I hereby certify that the information above is true and accurate.*
- ☐ As the referring physician, I agree to work in partnership with the bariatric clinic to provide my patient with the necessary medical care and support throughout the course of his/her bariatric treatment. *

Referring Provider Signature

Date (YYYY-MM-DD)