|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Information**  Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MHSC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_  Gender:    Male    Female  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone No. Home :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Alt. No :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Physician Information (please use stamp)**  Physician's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physicians Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Copy Report to (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Clinical Information**  Weight: \_\_\_\_\_\_Kg            Height: \_\_\_\_\_\_\_cm            BMI: \_\_\_\_\_\_ | | | | |
| **Health History:**  Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­  Coronary Artery Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diabetes Mellitus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dyslipidemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sleep Apnea  Chronic Pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Osteoarthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Skin Conditions (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mental Health Concerns  (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Respiratory Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GI(GERD, Crohn’s, Colitis)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Renal Disease:  Yes  No Dialysis |  Yes  No   Yes  No   Yes  No   Yes  No   Yes  No   Yes  No   Yes  No   Yes  No   Yes  No   Yes  No   Yes  No   Yes  No | **Additional past medical history (including surgeries, especially abdominal surgeries):**   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Is this patient on anticoagulation**   Yes    No  If yes, medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **List of Medications:**   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Questions to be completed by a physician or a nurse practitioner:**  **Does the patient currently:**  1. Smoke? (this includes all inhalants and E cigarettes)  Quit date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. Have alcohol and or substance abuse/dependency?  3. Have a significant psychiatric illness?  4. Made Recent attempts at weight loss within the      past 5 years?    Type/Activity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    5. Has the patient had Bariatric (weight loss) surgery (liposuction) or upper G.I surgery?  6. Is the patient ambulatory and able to perform ADL's?  7. This patient is cleared to perform moderate activity (i.e. brisk walking) | |  No   No   No   **No**     No   **No**   **No** |  **Yes**   **Not eligible** until abstinent for **6 months**   **Yes**  Treated **Untreated not eligible**   **Yes**  Treated **Untreated not eligible**   Yes  **If No –Patient is not eligible**     **Yes**   **Procedure:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date:\_\_\_\_\_\_\_\_\_\_\_ Send copy of operative report**   Yes  **If No –Not eligible**   Yes  **Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **For Centre for Metabolic and Bariatric Surgery Date Received:** (office use only)    Referring Physician Notified by:  Phone    Message    Mail  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient Notified by:  Phone    Message    Mail   Date:\_\_\_\_\_\_\_\_\_\_\_\_\_    **EOSS** (Edmonton Obesity Staging System Check stage that applies to patient)   Stage 1  Stage 2  Stage 3   Stage 4 | | | | **Date Received:** |

VGH 8425698 July 2012