



# Lap-Band® Procedure Referral Form

### Patient Information:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M \_\_\_ F \_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Smoker: Y \_\_\_ N \_\_\_ Addictions: Y \_\_\_ N \_\_\_

### Patient Medical History:

Current Medications:

Previous Surgical History:

- |   |   |
|---|---|
| - | - |
| - | - |
| - | - |
| - | - |
| - | - |

Previous or Current:

- |  |             |
|--|-------------|
| - Inflammatory diseases of the gastrointestinal tract              | Y ___ N ___ |
| - Severe cardiopulmonary diseases or other serious organic disease | Y ___ N ___ |
| - Potential upper gastrointestinal bleeding conditions             | Y ___ N ___ |
| - History of Deep Vein Thrombosis                                  | Y ___ N ___ |
| - Sleep Apnea  | Y ___ N ___ |
| - Diabetes   | Y ___ N ___ |

I consent to the following blood work for the above patient: Y \_\_\_ N \_\_\_

- CBC and differential, fasting glucose, sodium, potassium, chloride, CO2, creatinine, ALT, total billrubin, LDL,HDL, triglycerides, total cholesterol, AST, urea.
- TSH (if not done in past 3 months) Please forward current TSH results
- HbA1C (only if patient is diabetic)
- Urine microalbumin to creatinine ratio (only if patient is diabetic)

**Copy of blood tests results will be sent to Omni Surgery Centre. Patient should be advised that the blood tests will be collected at Allied Health Laboratory**

Patient has been advised that the Lap-Band® procedure is an uninsured service: Y \_\_\_ N \_\_\_

Patient has consented to my being informed on his/her progress through the program: Y \_\_\_ N \_\_\_

Patient has been advised that Omni Surgery Centre will contact him/her upon receipt of referral: Y \_\_\_ N \_\_\_

Physician Phone Number: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Physician Signature