Pre-Surgical Medical Clearance for Bariatric Surgery

Patient Name		**Date of Birth**	
Height		**Weight**	
Physician Name ***(Printed)***		**Phone**	
Practice Address		**City/State/Zip**	

Medical Examination:
Patients five (5) year weight history is as follows:

Year 1:		Year 2:		Year 3:		Year 4:		Year 5:	
Weight:		Weight:		Weight:		Weight:		Weight:	
BMI		BMI		BMI		BMI		BMI	

The patient has been diagnosed with the following co-morbid conditions; associated with morbid obesity: (check all that apply)

- ☐ Type 2 diabetes – controlled by oral medications
- ☐ Type 2 diabetes – controlled by injectable meds
- ☐ Obstructive sleep apnea
- ☐ Hypertension
- ☐ Coronary Artery disease
- ☐ Osteoarthritis of the ________________
- ☐ Degenerative Disc Disease
- ☐ Congestive Heart Failure
- ☐ Other conditions associated with morbid obesity: _________________________
- ☐ Does not apply, patient's Body Mass Index (BMI) is greater than 40

Patient has attempted and been unsuccessful with the following weight loss programs:

- ☐ Physician directed
- ☐ Weight Watchers/Commercial
- ☐ Dietitian/Nutrition directed
- ☐ Other: __________________________

After completing a thorough evaluation on _________________________ he/she **is** medically cleared for Bariatric Surgery. **Bariatric Surgery is recommended.**

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Physician Signature Date

Please fax to North Kansas City Hospital Bariatric Center 816-346-7212/ Questions please call 816-691-5048 Opt #4