HÔPITAL VICTORIA HOSPITAL

Centre for Metabolic and Bariatric Surgery
Referral Form

Please complete form and send to:

Victoria Hospital
2340 Pembina Hwy, Winnipeg, MB R3T 2E8
Phone: (204) 477-3540 Fax: (204) 477-3299

Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg

Patient Demographics (*please print clearly*)			
Name:			
Mailing Address		City/Town	Postal Code
Phone Number(s) (*day/after hours*)		Email address	
Gender ☐ Male ☐ Female ☐ Non-Binary	Age:	Date of Birth (dd-mmm-yyyy)	Personal Health I.D. Number
Contact person (*relation to patient*)		Phone Number	

Physician Information		
Physician's Name:		
Physician's Signature		
Mailing Address	City/Town	Postal Code
Copy Report to (*if different than referring provider*)		

MANDATORY *MUST BE COMPLETED ---------- Note*: *Eligible BMI – 30-34.9 with comorbidities / 35 – 65 with or without comorbidities*

***Weight (kg):**	***Height (cm):**	***BMI:**

Health History

Hypertension	☐ Yes ☐ No	Dyslipidemia	☐ Yes ☐ No
Coronary Artery Disease	☐ Yes ☐ No	Diabetes Mellitus	☐ Yes ☐ No
Respiratory Disease	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
GI (GERD, Crohn's, Colitis)	☐ Yes ☐ No	Active Diagnosis of Binge Eating	☐ Yes ☐ No
Renal Disease	☐ Yes ☐ No	Chronic Pain	☐ Yes ☐ No
Dialysis	☐ Yes ☐ No → **If yes, not eligible**	Osteoarthritis	☐ Yes ☐ No
Cancer ☐ Yes ☐ No → if yes, type of Cancer and Date (dd-mmm-yyyy)		Skin Conditions	☐ Yes ☐ No → If yes, please specify

Additional Medical History, Surgeries (especially abdominal and GI surgeries):

_____
_____
_____
_____

Previous Bariatric (weight loss) Surgery ☐ Yes ☐ No
If yes, Date of Procedure: dd-mmm-yyyy Type of Bariatric Procedure (i.e. gastric bypass, sleeve, lapband): _____
Location of Procedure (i.e. Province or Country):_____

Is the patient on an Anticoagulation? ☐ Yes ☐ No
If yes, what medication:

List all Medications:

_____
_____
_____

Does the patient currently:

Smoke (**includes ALL INHALANTS**: i.e. E-cigarettes, cannabis)? Quit date (if applicable): dd-mmm-yyyy	☐ Yes ☐ No → **If yes, not eligible until abstinent for 6 months**
Alcohol and or substance abuse/dependency?	☐ Yes ☐ No → **If yes, not eligible until abstinent for 1 year**
Significant psychiatric illness?	☐ Yes ☐ No → ☐ Treated → **If untreated, not eligible**
Made recent weight loss attempts within the last 5 years?	☐ Yes ☐ No → Type/Activity:
Is the patient cleared to perform moderate activity (i.e. Brisk Walking)?	☐ Yes ☐ No
Is the patient ambulatory and able to perform ADL's?	☐ Yes ☐ No

CENTRE FOR METABOLIC AND BARIATRIC SURGERY (OFFICE USE ONLY)

EOSS (Edmonton Obesity Staging System) Check stage that applies to patient: ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Stage 4	Date Received (dd-mmm-yyyy) Approved: ☐ Yes _____ ☐ No_____