SALHN GP PLUS BARIATRIC SURGERY PROGRAM REFERRAL (MR-BSR)

Facility/Site: ....

SA Health UR No: ....
Surname: ....
Given Name: ....
Second Given Name: ....
D.O.B: ....Sex/Gender ....

Referrals to be faxed to Fax: (08) 7425 8248 **Phone enquiries can be directed to Phone: (08) 7425 8200 (opt 1)**
Referrals can be emailed to: SALHNWeightManagementServices@sa.gov.au

REFERRAL CRITERIA FOR BARIATRIC SURGERY

- ☐ BMI > 35 with 2 or more comorbidities
- ☐ BMI > 45 with 1 or more comorbidity
- ☐ Aged 18—55 at time of referral
- ☐ No alcohol or drug-dependency
- ☐ Committed to program and making lifestyle changes
- ☐ No unresolved psychiatric pathologies

Comorbidities

- ☐ Diabetes (medication dependent)
- ☐ Obstructive sleep apnoea
- ☐ Hypertension
- ☐ Ischemic heart disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ Hyperlipidaemia
- ☐ Impaired mobility

SERVICE INFORMATION

There will be an initial appointment with the Nurse Consultant. The expectation is that the investigation and optimisation of comorbidities particularly sleep apnoea, will continue to occur in primary care while your patient is on the waiting list. Patients must attend a six month pre-surgical assessment program with the BMI clinic clinicians.

REFERRAL URGENCY

Urgency	☐ Urgent	☐ Semi Urgent	☐ Non urgent

REFERRER INFORMATION

Referrer's name		Provider Number (if applicable)	
Practice/Organisation Name		Phone	
Address			
Referrer's signature (Electronically signed by)		Date	

GENERAL PRACTITIONER DETAILS (if not referrer)

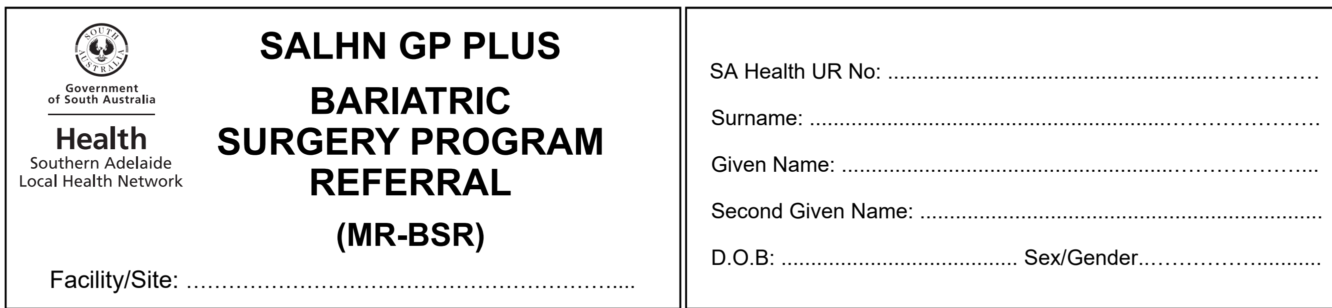
Doctor's name		Surgery name	
Surgery address, phone and fax number			

PATIENT DETAILS

Address			
Preferred phone		Alternative phone	
Medicare number		Expiry date	
Is the patient of Aboriginal or Torres Straight Islander origin?	☐ No, neither ☐ Yes, Aboriginal	☐ Yes, Torres Strait Islander ☐ Yes, both	

BARIATRIC SURGERY PROGRAM REFERRAL

MR-BSR



Government of South Australia

Health
Southern Adelaide
Local Health Network

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PATIENT DETAILS continued

Is an interpreter required?	☐ Yes ☐ No	Language	
Patient care details (if relevant)			

BASELINE PATIENT DATA

Age (at time of referral)		Weight	
BMI (current)		Height	

REFERRAL INFORMATION

Has the patient had previous bariatric surgery	☐ Yes ☐ No	If yes, please specify date and health facility
Has the patient had previous abdominal surgery	☐ Yes ☐ No	
Current medical conditions		
Current medications		
Any other relevant past medical history		
Allergies		
Relevant social factors		
Other relevant health professionals involved in the patient's care (including contact details)		

Please attach Health Summary for assessment including sleep studies and recent blood tests.