Alberta Health Services

Affix patient label within this box

Calgary Bariatric Surgery Clinic Adult Referral

Please **Fax** completed form to Endocrinology & Metabolism Program at 403.476.9626 or **Call** 403.955.8088.

Referrals with missing or incomplete information will not be processed

Patient Demographics *(Please print clearly)*			
Name *(last, first, middle)*			Date of Birth *(yyyy-Mon-dd)*
Street address	City	Postal Code	Phone number *(day)*
Mailing address *(if different)*	City	Postal Code	Phone number *(after hours)*
Email address		Gender	PHN/ULI

Referring Physician / Nurse Practitioner (NP)	**Primary Care Physician / NP** *(If different than Referring Provider)*
Name	Name
Phone number	Phone number
Fax number	Fax number
Practitioner Identification Number	Practitioner Identification Number
Primary Care Network (PCN)	Primary Care Network (PCN)

Specialists / Consultants involved in patient's care		
Name	Specialty	Phone number
Name	Specialty	Phone number

Referral Criteria

1. BMI greater than or equal to 40 OR
2. BMI greater than or equal to 35 with any weight-related co-morbidity such as cardiovascular disease, type 2 diabetes mellitus, sleep apnea, gall bladder disease, osteoarthritis, hypertension and/ or chronic pain.
3. 18-64 years of age
4. Resident of Alberta

Current BMI ________ kg/m^2 | Highest Recorded Weight ________ lb Date *(yyyy-Mon-dd)* __________________

Current Weight ________ kg or ________ lb Date *(yyyy-Mon-dd)* ________________ ☐ measured ☐ reported

Current Height ________ cm or ________ in Date *(yyyy-Mon-dd)* ________________ ☐ measured ☐ reported

EOSS Stage *(Edmonton Obesity Staging System - See Page 2)*

Diabetes History
☐ No
☐ Yes, Date of diagnosis *(yyyy-Mon-dd)* ________________

Has the patient had previous bariatric surgery? ☐ No ☐ Yes, if yes specify type of surgery ____________________
Has a reversal been done? ☐ No ☐ Yes Date *(yyyy-Mon-dd)* ____________________

Is patient a current smoker? ☐ No ☐ Yes
Does patient have significant mental health issues *(severe personality disorder, active psychosis, active substance dependencies, recent suicidal ideation or attempt in the past 6 months)* or has major cognitive or psychosocial issues that could be a barrier to lifestyle/behaviour changes? ☐ No ☐ Yes

Special Requirements

☐ Patient is unable to participate in group treatment *(Please specify)* ____________________
☐ Hearing, visual impairment *(Please specify)* ____________________
☐ Activity (Mobility) limitations, requires oxygen, etc *(Please specify)* ____________________
☐ Unable to read or speak English *(Please specify language)* ____________________
Translator / contact person ____________________ Phone number ____________________

Affix patient label within this box

Calgary Bariatric Surgery Clinic Adult Referral

Supporting Documents
Include relevant documentation that may inform Bariatric Assessment such as blood work, diagnostic imaging, consultant letters, discharge summaries, medications. See the Alberta Referral Directory for a complete list of required information

Communication with Referring Physicians
■ Each appointment is documented on a progress report and faxed to the referring physician to assist in communication. ■ Obesity management (and other chronic disease management) is done according to clinical practice guidelines. ■ Laboratory requisitions for appropriate laboratory work related to patient care (e.g., post surgery) will be done in collaboration with primary care procedures and guidelines *(available upon request)* in accordance with provincial laboratory work protocol. ■ Medication adjustments or recommendations may be made according to program guidelines *(available upon request)* and/or specific physician orders.

Edmonton Obesity Staging System (EOSS)	
0	No apparent risk factors (e.g., blood pressure, serum lipid and fasting glucose levels within normal range), physical symptoms, psychopathology, functional limitations and/or impairment of well-being related to obesity.
1	Presence of obesity-related subclinical risk factors (e.g., borderline hypertension, impaired fasting glucose levels, elevated levels of liver enzymes), mild physical symptoms (e.g., dyspnea on moderate exertion, occasional aches and pains, fatigue), mild psychopathology, mild functional limitations and/or mild impairment of well-being.
2	Presence of established obesity-related chronic disease (e.g.,hypertension, type 2 diabetes, sleep apnea, osteoarthritis), moderate limitations in activities of daily living and/or well-being.
3	Established end-organ damage such as myocardial infarction, heart failure, stroke, significant psychopathology, significant functional limitations and/or impairment of well-being.
4	Severe (potentially end-stage) disabilities from obesity-related chronic diseases, severe disabling psychopathology, severe functional limitations and/or severe impairment of well-being.

Reference: Padwal RS, Pajewski NM, Allison DB, Sharma AM. Using the Edmonton obesity staging system to predict mortality in a population-representative cohort of people with overweight and obesity. CMAJ October 4, 2011; 183 (14) E1059-E1066

Alberta Health Services

Date: ____________________________

Name: ___________________________

Date of Birth: ____________________

Healthcare #: ____________________

ADHD screening

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an "X" in the box that best describes how you have felt and conducted yourself over the past 6 months.	**Never**	**Rarely**	**Sometimes**	**Often**	**Very Often**
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Date: ___________________________

Name: __________________________

Date of Birth: ___________________

Healthcare #: ___________________

EQ5D

Under each heading, please tick the one box that best describe your health TODAY.

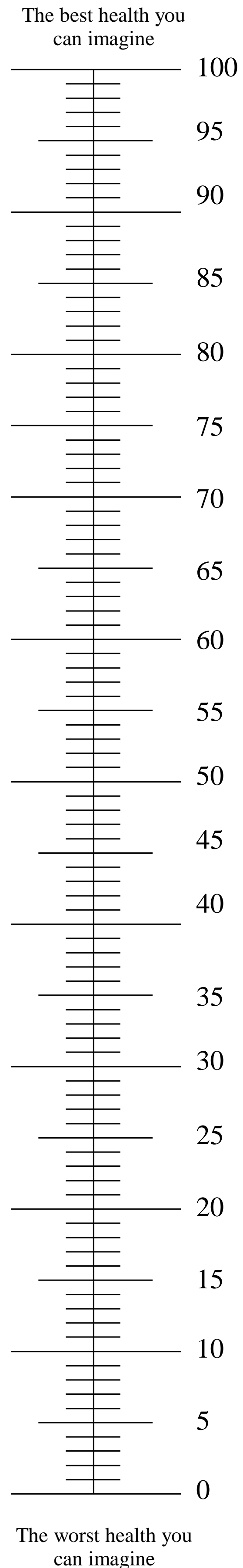
MOBILITY	
I have no problems in walking about	
I have slight problems in walking about	
I have moderate problems in walking about	
I have severe problems in walking about	
I am unable to walk about	
SELF-CARE	
I have no problems washing or dressing myself	
I have slight problems washing or dressing myself	
I have moderate problems washing or dressing myself	
I have severe problems washing or dressing myself	
I am unable to wash or dress myself	
USUAL ACTIVITIES (e.g. work, study, housework, family, or leisure activities)	
I have no problems doing my usual activities	
I have slight problems doing my usual activities	
I have moderate problems doing my usual activities	
have severe problems doing my usual activities	
I am unable to do my usual activities	
PAIN/DISCOMFORT	
I have no pain or discomfort	
I have slight pain or discomfort	
I have moderate pain or discomfort	
I have severe pain or discomfort	
I have extreme pain or discomfort	
ANXIETY/ DEPRESSION	
I am not anxious or depressed	
I am slightly anxious or depressed	
I am moderately anxious or depressed	
I am severely anxious or depressed	
I am extremely anxious or depressed	

May 2023

Alberta Health Services

Name: ____________________________

EQ5D



- We would like to know how good or bad your health is **TODAY**.
- This scale is numbered from 0 to 100
- 100 means the **best** health you can imaging
  0 means the **worst** health you can imagine
- Mark an X on the scale to indicate how your health is TODAY
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =

May 2023

Alberta Health Services

Date: ___________________________

Name: __________________________

Date of Birth: ___________________

Healthcare #: ___________________

GAD-7 screening for anxiety				
Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems?	**Not at all** **0**	**Several days** **1**	**More than half the days** **2**	**Nearly every day** **3**
1. Feeling Nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				

General Stress

Check the number that best indicates your general level of stress.

1 2 3 4 5 6 7 8 9 10

Not stressed ←→ very stressed

List your 3 main stressors

1______________________ 2______________________ 3______________________

Date: ____________________

Name: ____________________

Date of Birth: ________________

Healthcare #: ________________

PHQ-9				
Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all** **0**	**Several days** **1**	**More than half the days** **2**	**Nearly every day** **3**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure, or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite; being so fidgety or restless that you have been moving around more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way.				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Alberta Health Services

Date: ______________________

Name: ______________________

Date of Birth: ________________

Healthcare #: ________________

Calgary Adult Bariatric Surgery Clinic

SLEEP

Do you have sleep apnea?	YES ☐	NO ☐
If yes, is it being treated?	YES ☐	NO ☐

STOP Bang Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

Please answer the following questions to determine if you may be at risk for sleep apnea:

Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	YES ☐	NO ☐
Do you often feel TIRED, fatigued, or sleepy during daytime?	YES ☐	NO ☐
Has anyone OBSERVED you stop breathing during your sleep?	YES ☐	NO ☐
Do you have or are you being treated for high blood PRESSURE?	YES	NO
Is your BMI more than 35kg/m2?	YES ☐	NO ☐
Is your AGE over 50 years old?	YES ☐	NO ☐
Is your NECK circumference > 16 inches (40cm)?	YES ☐	NO ☐
Is your GENDER Male?	YES ☐	NO ☐

Please answer as many of these questions as you can. If you do not know an answer, please skip it and discuss it with the Registered Nurse at your appointment.

Date: ______________________

Name: ______________________

Date of Birth: ________________

Healthcare #: ________________

Gastroesophageal Reflux Disease-Health Related Quality of Life Instrument GERD-HRQL

• **Scale**: No symptoms = **0**; Symptoms noticeable, but not bothersome = **1**; Symptoms noticeable and bothersome, but not every day = **2**; Symptoms bothersome every day = **3**; Symptoms affect daily activities = **4**; Symptoms are incapacitating, unable to do daily activities = **5**

Questions	0	1	2	3	4	5
1. How bad is your heartburn?						
2. Heartburn when lying down?						
3. Heartburn when standing up?						
4. Heartburn after meals?						
5. Does heartburn change your diet?						
6. Does heartburn wake you from sleep?						
7. Do you have difficulty swallowing?						
8. Do you have pain with swallowing?						
9. Do you have bloating or gassy feelings?						
10. If you take medication does this affect your daily life?						

How satisfied are you with your present condition? Satisfied _____Neutral _____Dissatisfied ______

For office coding ___+ ___+ ___+ ___+ ___+___+ ___

= Total Score: ____

Alberta Health Services

Date: ______________________

Name: ______________________

Date of Birth: ________________

Healthcare #: ________________

AUDIT

For each question below, check mark the answer that best describes you.

One Standard Drink =

341 ml (12 oz) bottle of 5% alcohol beer, cider or cooler

142 ml (5 oz) glass of 12% wine

43 ml (1.5 oz) shot of 40% hard liquor (vodka, rum, whiskey, gin, etc.)

Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	**Daily or almost daily**
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	**Daily or almost daily**
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
	______	______	______	______	______

Total Score = ____

Alberta Health Services

Name: ______________________

Date of Birth: _________________

Healthcare #: _________________

Definition:
Smoking and use of nicotine products refers to smoking, vaping, or inhaling any substance (nicotine, marijuana, shisha etc.), currently using nicotine products (chewing tobacco) or nicotine replacement therapies (patch, gum, inhaler, lozenge, or nasal spray)

Smoking and Nicotine Products Screening Tool		
In the last **12 months** have you smoked or used any of the following products?	**Yes**	**No**
A. Cigarettes		
B. Smoke Cannabis		
C. e-Cigarettes or Vaporizers		
D. Shisha		
E. Nicotine Products (ex. chewing tobacco)		
F. Nicotine Replacement Therapies		
G. Other substances		
Total number of “Yes” answers:		

Calgary Adult Bariatric Surgery Clinic
Richmond Road Diagnostic & Treatment Centre
1820 Richmond Rd SW, Calgary, AB, T2T 5C7
p: (403)955-8088 f: (403) 476-9626
cal.bar@ahs.ca