Innovative Care Management

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Healthcare savings and satisfaction through innovation and respect.

Please complete and FAX this questionnaire with the following clinical information to 503-654-8570:

Submitted By: ____________________________ Phone: _____________________ Fax: _________________

Patient Name: ____ DOB: _____________________

Please fax the following clinical data:

- ❑ Recent History & Physical
- ❑ Bariatric history including any previous bariatric surgeries and BMI for last 2 years
- ❑ Co-morbid conditions *(i.e. Diabetes, GERD, etc.)*
- ❑ Diagnostic testing results *(i.e., EGD, MRI, HIDA, etc.)*
- ❑ Endocrine testing - **required:** TSH level (Thyroid Stimulating Hormone)
- ❑ Psychiatric Evaluation
- ❑ If diagnosis of Obstructive Sleep Apnea (OSA) – send the Polysomnogram (PSG) report
- ❑ Compliance documentation to a multidisciplinary non-surgical program including low calorie diets, exercise & behavior modification of at least 3-6 months

Indicate the name of the Bariatric Program in which the physician participates and from which the patient is receiving care:____

Is this a Center for Excellence? _________YES ________NO
If yes, please include the accreditation certificate or letter of approval, along with the dates for the certification period.

Is this a Multidisciplinary Program? _________YES ________NO
If yes, please indicate services you provide access to:

- ❑ Psychological counseling
- ❑ Exercise counseling
- ❑ Nutritional counseling
- ❑ Support group meetings

Employer/Plan Name: ___________________________________ Plan ID: ____________________

Please indicate the ***date of service*** for this pending request: _________________ or ❑ Not Scheduled

Facility:____Phone:_____________________________

Physician:____Phone:_____________________Fax:_________________

Please identify the diagnosis and surgical procedure(s) requested:

ICD9 code(s): ____

CPT: ________________ Description: ____________________________________

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Indicate if the procedure will be performed: _______Inpatient ________Outpatient