Dartmouth Health

Dartmouth Hitchcock Medical Center

Phone: (603) 653-2226
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Weight Center | New Outpatient Consult Order

Please note: An appointment consultant will contact your patient to schedule an outpatient appointment. Incomplete or illegible information on this form will result in a request for additional information which will delay the scheduling of your patient. Patient will be sent a questionnaire before their first visit which will need to be completed. Please let your patient know that if they do not hear from us within 72 hours to call (603) 650-5261 for immediate assistance.

Please check one:

❑ Urgent (within 10 days)
- ❑ Recent hospitalization in last 3 months for heart failure, heart attack, stroke, respiratory failure.
- ❑ Needs organ transplant.
- ❑ Idiopathic Intracranial HTN (IHH) (pseudotumor cerebri) with vision changes.
- ❑ Unable to leave home without difficulty due to weight/generally does not leave home.
- ❑ Needs urgent surgery for the following conditions: (Cancer, joint surgery, anti-reflux surgery, Hernia)
- ❑ BMI >60

❑ Stable (next available): fax this form with all pertinentinformation

❑ Patient has been seen previously by DHMC Weight Center

Diagnosis and reason for consult: _____

❑ **All information is in eDH**

If outside eDH, please fax the following **required** information with this form to: **Medically Urgent Fax: (603) 640-1909**.
Patient demographics, recent office notes with BMI and problem list, medication list, recent labs (A1c, CMP, CBC, TSH, Lipids)

❑ **Sleep study completed?**

If so, where _____ if patient is at high risk, please refer for sleep study.

❑ **Cardiovascular work up?** If so, where _____

❑ **Being seen by Endocrinology?** If so, where _____

❑ **Liver imaging?** If so, where _____

❑ **Previous bariatric surgery?** If so, where/when_____