PennState Health
Milton S. Hershey
Medical Center

Department of Surgery
MIS/Bariatrics

Penn State Health Milton S. Hershey Medical Center
Penn State Surgical Weight Loss 4000
Vine St. M.C. HP20
Middletown, Pa 17057

Tel: 1-877-609-6848
Fax: (717) 531-0806

Please schedule a physical with your family doctor for completion of this form

Dear Doctor,

Your patient has registered for the Penn State Hershey Surgical Weight Loss program and is interested in pursuing weight loss surgery to manage his/her obesity.
Your patient will need the following completed:

1) **History and Physical**
2) **Labs**:
   - Fasting Lipid Profile
   - Comprehensive Metabolic Panel (should include Liver Function Tests)
   - CBC, Platelet
   - Glycohemoglobin
   - TSH
   - Vitamin D25

Please fax, mail, or have patient hand deliver the following information to allow us to complete the screening process:

1) **History and Physical**: documentation of evaluation either through copy of medical record (please make sure all areas on form attached are addressed) or by using the form on the back of this sheet. In particular, please document if your patient is experiencing snoring, daytime sleepiness, or any other symptoms relating to possible sleep apnea. Before a sleep study can be done, documentation is required.
2) **Progress Notes:** the last 6 months of progress notes. (Not necessary if physician is in the HMC system)
3) **Results from Testing:** Please include any pertinent testing that would assist us in our evaluation of risk status for surgery. (Cardiac, Pulmonary, Sleep, GI, Psychiatric, etc.)
4) **Labs:** Results from the above required labs

Due to insurance requirements or at the request of one of our providers, your patient may need to complete additional testing. If they opt to have testing done outside of the Hershey Medical Center, they may be asked to work with your office; please fax all such outside reports to our office for review and documentation. These documents are essential to assist us in determining patient risk for surgery and to achieve insurance authorization.

Thank you for helping us to provide the best possible care to our mutual patient. Please send all correspondence to the fax or address listed above. If you have any question, please do not hesitate to contact us.

Sincerely,
Ann M. Rogers, M.D.
Director, Penn State Hershey Surgical Weight Loss

To: Penn State Hershey Surgical Weight Loss Program /4000 Vine Street, Middletown, PA 17057/Fax:717-531-0806

Ann M. Rogers, M.D., Director Randy S. Haluck, M.D. Jerome Lyn-Sue, M.D.

PATIENT NAME: ___________________________ **DOB:** __________________

I am sending my patient to you for evaluation and consideration of entrance into the Penn State Surgical Weight Loss Program.

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐Other
☐ Native Hawaiian/Pacific Islander ☐ Two or More Races ☐ American Indian/Alaskan Native
AGE: ______ years old
SEX: Male / Female
WEIGHT: _____ lbs on Date:______
HEIGHT: ____ft_____in.

Medical Diagnoses: (please include any testing results within past 2 years)

___HTN ___Diabetes: self monitors, oral meds, insulin, hgbA1c, complications

___Joint pain ___Hypothyroid ___Hyperlipidemia ___CAD

___Coagulopathy ___Pulmonary disease ___Sleep Apnea ___Gout

___Depression ___Stress Incontinence ___GERD ___Arthritis
Other:____
Physical Limitations /ability to exercise:____

Symptoms of Sleep apnea: ie: snoring, daytime sleepiness etc.:

Surgical History:

Current Medications and dosage:

Allergies:

Psychological History: (admissions, suicide attempts, uncontrolled eating or mood disorders, abuse, anxiety, post traumatic stress disorders and name of therapist if applicable)

Substance Abuse History:

My patient IS / IS NOT seen on a regular basis. My patient has been COMPLIANT / NON COMPLIANT with treatment recommendations and medication regime. Please note reason for non compliance if applicable:____.

Please comment on anything that may affect the ability of this patient to understand, follow through or be successful in the Penn State Surgical Weight Loss Program or after a life changing surgery like surgical weight loss.)____
____

Physician Signature:__________________________Printed Name:________________________Date_________________