

UAB *EatRight* Bariatric Medicine Clinic
PATIENT REFERRAL FORM
TELEPHONE: 205-934-5564 FAX: 205-934-7050

www.eatright.uab.edu

DATE: _____

PATIENT DEMOGRAPHICS

MR# _____ **SS#** _____ / _____ / _____

Last Name: _____ **First Name:** _____, **MI:** _____

Date of Birth: _____ / _____ / _____ **Sex:** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Home Phone () _____ **Work Phone ()** _____

Cell Phone () _____ **Email:** _____

May we contact the patient through email? Yes No

Height _____ **ft** _____ **inches *** **Pre-surgical Weight** _____ ***** **Current Weight** _____ *****

Date of Surgery _____ / _____ / _____ ***** **BMI:** _____

* Information must be completed prior to appointment scheduling

REFERRING PHYSICIAN INFORMATION:

Physician: _____

Office Contact: _____ **Telephone** _____

Fax: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Insurance: _____ **Secondary Insurance:** _____

Note: If Medicaid patient please attach referral form

BARIATRIC MEDICINE OFFICE USE ONLY

Left Msg.- Date _____

Appointment date: _____ Time: _____

Spoke to Inquirer- Date _____

Physician: _____

Remedy MD Registration Completed _____

Labs _____ EKG _____