

# Consultation Request

New Patient Coordinator Tel: 617-726-0373  
 E-mail: [weightcenter@mgh.harvard.edu](mailto:weightcenter@mgh.harvard.edu)

Today's Date: \_\_\_\_\_

**Type of Referral**  
*(\*check one only)*

**Referral for Obesity Medicine Consultation\***  

- Comprehensive evaluation involving a physician, a dietitian and a psychologist

**Referral for Weight Loss Surgery Consultation\***  
*Patient must meet both of these conditions*

- BMI >35
- Desires weight loss surgery

**Special Considerations:**  
*(check all that apply)*

- Complications of previous weight loss surgery**  
 **Weight loss to proceed a medical/surgical procedure**

**Requested urgency of consultation:**  
*(will be reviewed by our Medical Director)*

- Urgent**                       **Routine**

**Clinical Information**  
*(\*required information)*

**\*Weight:** \_\_\_\_\_ **\*Height:** \_\_\_\_\_ **BMI (if known):** \_\_\_\_\_

**Major weight-associated disorders** *(check all that apply):*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Diabetes mellitus                   | <input type="checkbox"/> Sleep apnea         | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Severe back or joint pain           | <input type="checkbox"/> Asthma or COPD      | <input type="checkbox"/> Major Mental illness |
| <input type="checkbox"/> Heart disease                       | <input type="checkbox"/> GERD                | <input type="checkbox"/> Anxiety disorder     |
| <input type="checkbox"/> H/o Cancer: Type _____              | <input type="checkbox"/> Fatty liver disease | <input type="checkbox"/> Infertility or PCOS  |
| <input type="checkbox"/> Other major medical problems: _____ |  |   |

*If you have discussed this referral with a Weight Center provider please list provider name:* \_\_\_\_\_

**Patient Contact Information**

**Patient Full Name:**  
 (Last, First, MI) \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

**Gender:**                       Male     Female

**Patient Address:** \_\_\_\_\_

**City/ State/ Zip:** \_\_\_\_\_

**MGH Unit No:** \_\_\_\_\_

If no number is available, please instruct the patient to call the MGH Registration Center at 866-211-6588.

**Daytime Phone:** \_\_\_\_\_

**Evening Phone:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**Patient will require an interpreter;**    **Primary Language:** \_\_\_\_\_

**Referring Provider**

**Name of Provider:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Practice Name:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Are you the patient's PCP?**     Yes     No

**If not, PCP Name:** \_\_\_\_\_

**Provider E-mail address:** \_\_\_\_\_

**Please fax this form to 617-724-2535**