WellSpan Bariatric Surgery Program

New Patient Information Booklet
Thank you for attending the WellSpan Bariatric Surgery Information Session.

If you are interested in moving forward with the WellSpan Bariatric Surgery Program, please follow these easy steps:

- Fill out the **Interest Form** online and submit it before logging off.
  - We will check your insurance coverage & call you to make an appointment.

- If your insurance requires a referral before seeing the surgeon/specialist; obtain this from your primary care doctor.
  - Some insurance companies do not require a referral; check with your insurance provider.

- Send the **Primary Care Doctor Support Document** to your family physician.

- Begin attending the Medically Supervised Weight Loss Program.
  - Our office will let you know if your insurance requires these classes
  - Our office will provide you with the class dates & times when scheduling your initial nutrition class visit.

- If your doctor is **not** a WellSpan doctor, please obtain your recent medical records and bring them to your first surgeon visit.
PRIMARY CARE DOCTOR SUPPORT DOCUMENT
(To be completed by your primary care physician’s office)

Date: __________________ (Enter Today’s Date)

_______________________________________ is an active patient of mine and is currently being evaluated for bariatric surgery at (choose location):

☐ WellSpan Bariatric Surgery York
  25 Monument Road, Suite 105
  York, PA  17403
  (P) 717-851-7575
  (F) 717-812-5154

☐ WellSpan Bariatric Surgery Ephrata
  63 W. Church Street
  Stevens, PA  17578
  (P) 717-721-8795
  (F) 717-336-8284

☐ WellSpan Bariatric Surgery Summit
  1624 Orchard Drive
  Chambersburg, PA  17201
  (P) 717-267-6427
  (F) 717-267-6423

My patient has the following selected medical conditions (check all that apply):

☐ Diabetes Type I  ☐ Arthritis
☐ Diabetes Type II  ☐ Infertility
☐ Hypertension  ☐ Incontinence
☐ Hypercholesterolemia  ☐ Joint Pain: (location):
☐ Sleep Apnea

☐ My patient has tried traditional medical weight loss under my supervision and failed.

Medical weight loss programs attempted:
_____________________________________________________
_____________________________________________________
_____________________________________________________

My patient is currently taking the following medications (Please check if list is attached ☐):
_____________________________________________________
_____________________________________________________
_____________________________________________________

It is my belief that this patient would be a good candidate for weight loss surgery. ☐ Yes ☐ No

Additional comments: ______________________________________________________________
____________________________________________________________
____________________________________________________________

Sincerely,

Provider Signature & Printed Name: ___________________________ Date: ____________

Practice Name: _____________________________

Practice Address & Phone: ____________________________
To Qualify for Weight Loss Surgery at WellSpan: BMI ≥ 35 AND weight related illnesses OR BMI ≥ 40

Endoscopic Procedures: BMI 30-40