Community Health, Inc.

BARIATRIC SURGERY EVALUATION

Oregon Health Plan

OHP Client ID: _____ **DOB:** _____

Patient Name: _____

Primary Diagnosis: _____ **ICD-9:** _____

Primary Care Provider: _____

Contact: _____ **Phone:** _____ **Fax:** _____

Required Clinical Conditions:	**Please circle appropriate response:**	
BMI ≥ 35	**Yes**	**No**
Age ≥ 18	**Yes**	**No**
Diabetes Mellitus II	**Yes**	**No**
Willing to abstain from nicotine, illicit drugs and alcohol	**Yes**	**No**
Willing to not become pregnant for 2 years	**Yes**	**No**
No uncontrollable psychological contraindication	**Yes**	**No**

In my professional opinion this client is a medically appropriate candidate for bariatric surgery.

Referring Provider Signature: _____ **Date:** _____

Bariatric Surgery Criteria: http://www.oregon.gov/OHPPR/HSC/current_prior.shtml

Please submit this form with records to:

Oregon Health Plan Authorization/Referrals
P.O. Box 40384
Portland, OR 97240

503.265.2940
1.888.474.8540
Fax 503.243.5105