Memorial Hermann Health System
Memorial Hermann NewStart™ Surgical and Medical Weight Loss Care Concierge Consultation Referral Order

Email: NewStartCareConcierge@memorialhermann.org
Care Concierge Phone: 713.338.7580 or Care Concierge E-fax: 713 338 7581

Epic referrals are preferred. If unable to use Epic, this form may be used.

PATIENT INFORMATION * *Required fields*

Date of Referral:	Preferred MH Location: ☐ Cypress ☐ Memorial City ☐ Southeast ☐ Sugarland ☐ TMC ☐ Woodlands		
Patient Name*:			
Address*:			
City*:		State*:	Zip Code*:
Email*:	Primary Phone*:		May we leave a message?* ☐ Yes ☐ No
Date of Birth: _____	Height: _____	Weight: _____	BMI: _____
Type of Surgery interested in: ☐ Gastric Banding ☐ Sleeve Gastrectomy ☐ Gastric Bypass ☐ ESG / ☐ Not Sure			

INSURANCE INFORMATION:

Primary Insured Information

Name: _____ Last: _____ First: _____ M.I._____ DOB: _____

Age: _____ Home Phone: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____ Employer: _____

Insurance Company: _____ Insurance Company toll free number: _____

Member ID Number: _____ Group Number: _____

Secondary Insurance: _____ Insurance Company toll free number: _____

Member ID Number: _____ Group Number: _____

PRESENCE OF OBESITY RELATED CONDITIONS – CHECK ALL THAT APPLY

- ☐ Diabetes Mellitus – Type 1 Or 2
- ☐ Hypertension
- ☐ Sleep Apnea
- ☐ Arthritis/Degenerative Joint Disease In Major Weight Bearing Joints
- ☐ Gastroesophageal Reflux Disease
- ☐ Hyperlipidemia
- ☐ Fatty Liver Disease/Nash
- ☐ Pseudotumor Cerebri/ Idiopathic Intracranial HTN
- ☐ Polycystic Ovarian Syndrome
- ☐ Congestive Heart Failure

- ☐ **PATIENT HAS NO CO-MORBIDITIES**
- ☐ **Patient HAS NO history of Bariatric surgery**
- ☐ **Patient HAS history of Bariatric surgery**

Please provide any additional documentation if patient has a history of Bariatric Surgery for establishing care:

- ☐ Operative Report – provided by patient if applicable

Procedure Type: _____

Procedure Date: _____

Location: _____

Surgeon: _____

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

_____	_____	_____	_____	☐ AM ☐ PM _____	_____
Provider Signature	**Print Name**	**NPI/MHHS ID.**	**Date**	**Time**	**Contact No.**

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