

## **CHNCT BARIATRIC SURGERY REQUEST FORM**

Member's Name: \_\_\_\_\_ Member's ID#: \_\_\_\_\_

Plan: Husky \_\_\_\_\_

Charter Oak \_\_\_\_\_

Date of Surgery: \_\_\_\_\_

Hospital: \_\_\_\_\_

Surgeon: \_\_\_\_\_

Name of Contact: \_\_\_\_\_

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

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

Inpt: \_\_\_\_\_ #days: \_\_\_\_\_ Proc Code: \_\_\_\_\_ Diag Codes: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

**Clinical notes must be faxed to CHNCT for review**  
**Please fax request to 203-265-3994. Thank You**

**Please Include the following information:**

- Cardiac evals: EKG and Stress Test
- Pulmonary: PFT/Sleep Study
- Psych evaluation
- Nutrition: 6 months of supervised nutritional notes with weight

**\*\*PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF ALL CLINICAL INFORMATION TO PROCESS REQUEST\*\***