

# Obesity Surgery Center of Louisiana

## General Practitioner – Agreement to Care

Physician Name: _____	M.D.
Address: _____ _____	
Phone: ( _____ ) _____	Fax: ( _____ ) _____
Specialty: _____	

Dear Practitioner:

RE: \_\_\_\_\_ (PATIENT)

In signing this form, we ask that you agree to follow this patient in his/her care after Gastric Bypass surgery. The patient will undergo the surgery in Lake Charles Louisiana through the Obesity Surgery Center of Louisiana. Due to distance, the patient has asked that his/her care be continued through yourself, closer to their home. He/she will be followed exclusively by our surgeons during the two week postoperative period after which time we ask that you continue care to include:

- Office evaluations every at least every six months, sooner if necessary.
- Comprehensive laboratory workup every six months to evaluate basic metabolic status.

We will not expect you to cover any postoperative complications and the patient is always welcome to return to our clinic for care. We appreciate your help. We do ask that the patient obtain a copy of all laboratory testing and fax or mail it in to our office for our records. If you have any questions regarding this request, please do not hesitate to contact our office at (337) 433-1303.

Sincerely,

OTC Surgeons

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**Signature of Physician accepting request**