PATIENT REFERRAL FORM

FAX TO: 647.497.6006

PATIENT INFORMATION

NAME: ______________________

GENDER: ____ DATE OF BIRTH (DD/MM/YY): __________

ADDRESS: ______________________

CITY, POSTAL CODE: ______________________

OHIP #: ______________________

PHONE # (HOME & CELL): ______________________

REFERRING DOCTOR

NAME: ______________________

BILLING #: ______________________

ADDRESS: ______________________

CITY, POSTAL CODE: ______________________

PHONE #: ______________________

FAX #: ______________________

ALLERGIES / SENSITIVITIES / INTOLERANCES

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REASON FOR REFERRAL

- ☐ OVERWEIGHT/OBESITY
- ☐ PREDIABETES
- ☐ TYPE 2 DIABETES
- ☐ NON-ALCOHOLIC FATTY LIVER DISEASE (NAFLD OR NASH)
- ☐ POLYCYSTIC OVARY SYNDROME (PCOS)
- ☐ METABOLIC SYNDROME
- ☐ OTHER: ______________________

CURRENT MEDICATIONS

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RELEVANT MEDICAL HISTORY

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*** Please include a copy of all relevant blood work results, consult notes, and test results. Patients will be contacted directly to schedule an appointment. We will send you consult notes once they have been followed up.

SIGNATURE: ______________________ DATE: ______________________

PLEASE NOTE:
Patients with diabetes will be seen by our family medicine physician, who is a diplomate of The American Board of Obesity Medicine with a special interest in metabolic diseases, as such, patient engagement in this program may result in negation if they are enrolled in certain Primary care Enrolment Model (PEM). Kindly take this under consideration when rostering the patient for the duration of the program. Many thanks.