WEIGHT MANAGEMENT REFERRAL
649 Sheppard Ave West
Toronto, ON, M3H 2S4
TEL: (416) 508-5691 | FAX: (416) 398-2436

www.getwellforlife.ca

Dear doctor,

Your patient has expressed interest in weight management! Please complete and return fax, thanks!

PATIENT INFO:

(* Required elds)

Name: ______________________________ *
Date of Birth: ____________________ (dd-mm-yyyy)
Gender: __________
OHIP #: __________________ * Version: _______ *
Address: _________________________
____
City: ______________ Postal Code: __________
Phone: ___________________ *
Cell: ___________________
Email: ___________________
(personal, non-work)

Medical Reason for Referral: * (Examples: obesity, HTN, diabetes, cholesterol, metabolic syndrome, PCOS

Past Medical and Psychiatric Health: **Height:** _______ **Weight:** _______

Current Medications:

Referral request to Dr. Kevin Lai & Associates for integrated multidisciplinary, supportive coaching, medical management, nutritional counselling, cognitive and behavioural approach to helping clients reach their best weight.	**Physician Referral Required Services: #** Referring Physician Name: ____________________ * MOHLTC Billing Number: ____________________ * Referring Physician Phone: ____________________ * Referring Physician Fax: ____________________ * Physician Signature: ____________________ * Date of Referral: ____________________ *

*** Please send a copy of recent relevant blood work, investigations, imaging, and consults ***