

WEIGHT MANAGEMENT REFERRAL
649 Sheppard Ave West
Toronto, ON, M3H 2S4
TEL: (416) 508-5691 | FAX: (647) 478-7604



www.getwellforlife.ca

Dear doctor

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

PATIENT INFO:

Name: _____ * (* Required fields)
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:

<i>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.</i>	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 *****