Get Well Clinic
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getwell clinic.ca

Weight Management Program REFERRAL FORM:

Dear doctor

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

PATIENT INFO:

(* Required fields)

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:

	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 *****

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