

Please fax completed forms to:
905-385-5033

Contact booking desk at **905-521-2100 x 76990** for any further questions

Date of Referral _____

Patient Information

Patient Name: _____

DOB: _____ Male ___ Female ___

Health Card # _____ (OHIP)

Address: _____

_____ Postal Code: _____

Telephone: _____

Family Physician _____

Referring Physician Information

Name: _____

Address: _____

Postal Code: _____

Telephone: _____

Fax: _____

E-mail (Optional): _____

Physician Billing #: _____

Signature: _____

[] Weight Management [] Pediatric Lipid Clinic [] Exercise Medicine

Medical Conditions (check all that apply)

- | | | |
|---|--|--|
| ☐ Acanthosis Nigricans/ Hyperinsulinemia | ☐ Dyslipidemia | ☐ Microalbuminuria |
| ☐ ADHD/Neuro dev. disorder | ☐ Eating Disorder | ☐ Obstructive Sleep Apnea |
| ☐ Arthritis or related | ☐ Fatty Liver/Gallbladder Disease | ☐ Polycystic Ovarian Syndrome |
| ☐ Asthma | ☐ GERD | ☐ Pseudotumor Cerebri |
| ☐ Cancer | ☐ Hemophilia | ☐ SSCFE/Blount's |
| ☐ Cardiac | ☐ Hypertension | ☐ Spina Bifida |
| ☐ Cerebral Palsy | ☐ IBD | ☐ Type 1 Diabetes |
| ☐ Cystic Fibrosis | ☐ Kidney Disease | ☐ Type 2 diabetes |
| ☐ Depression/Anxiety | ☐ Medication induced weight gain | ☐ Family hx premature coronary artery disease |
| ☐ Other _____ | ☐ Mental Health (other) _____ | |

Details of Referral:

Medications:

Additional Information

Previous weight management interventions (if applicable):

☐ No intervention ☐ Community based program ☐ Primary care counselling ☐ Dietitian ☐ Multidisciplinary counselling

Interpreter Required? ☐ Yes ☐ No Primary Language: _____

Required Investigations and Documents (Please Attach)

Anthropometry: Date assessed (y/d/m) _____ Weight: _____ kg Height: _____ cm BMI%: _____

☐ Growth chart (if available) ☐ Fasting Lipid Profile ☐ Glucose ☐ Liver enzymes ☐ HbA1c ☐ TSH ☐ other