MD Weight Loss

Physician Referral Form for MD Weight Loss Program

DATE OF REFERRAL: _____

Patient Information:

Name: _____ DOB:_____ PHN: _____

Address: _____

Phone: (H) _____ (C) _____ Email: _____

Has the patient previously been on a weight loss program? □ Yes □No

Is the patient breastfeeding, pregnant, or trying to become pregnant? □ Yes □No

Past medical history:

□ Coronary Heart Disease □ Fatty liver (NAFLD) □ Diabetes

□ Osteoarthritis □ Stroke □ Hypertension □ Thyroid □ Cancer □Other _____

Mental Health:

□ Anxiety/Depression □ PTSD □ Sleep disorder □ Substance use disorder □ Bipolar disorder □ Eating disorder □ Other _____

Current medications:

_____

_____

Physician Information:

Referring Physician _____ Referring Physician Signature: _____ Telephone # _____ Fax #: _____ Prac ID: _____

Please fax to Central Referral at 1-866-641-6596

In person preferred:

□ South Calgary

4120 – 15 Sunpark Plaza SE

Virtual preferred:

□via phone □ Google meets /online

Please attach any relevant labs/investigations/consults.