



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.