Obesity Care Clinic
REFERRAL FORM - FAX TO 902-842-5142

Patient Name:		Health Card Number:		
Gender:	Pronouns:	Date of Birth: (YYYY/MON/DD)		
Address:		Weight (kg)	Height (cm)	BMI (kg/m^2)
Phone Number:				
Is it okay to leave a voicemail? ❑ Yes ❑ No				
Is patient aware of this referral and willing to participate in the program? ❑ Yes ❑ No				
Exclusions				
• Acute coronary syndrome, CVA or VTE in the past 3 months		• Active Eating Disorder		
• Pregnant or breast feeding		• Active Substance Use Disorder		
• Unstable mental health disorders		• BMI less than 30.0		

Inclusion Criteria

❑ **Adult with BMI greater than 30.0 (Asian population BMI greater than 27.0) with at least 1 adipose related co-morbidity**

Co-morbidities:

❑ Type 2 Diabetes ❑ OSA
❑ Dyslipidemia ❑ Hx of CVD
❑ Hypertension ❑ PCOS
❑ NAFLD ❑ Osteoarthritis
❑ Cerebrovascular Disease ❑ Infertility
❑ Other (ie: QOL concerns): _____

Pre-surgical Stream (For hip or knee joint replacement surgeon only)

Desired BMI Target: _____

Patient will be offered Optifast, calorie reduced meal plan or combination of both.

Is patient aware there is a cost associated with the Optifast product?

❑ Yes ❑ No

Estimated Surgery Date: _____ (YYYY/MON/DD)

Notes:

Is patient appropriate for group classes/able to contribute? ❑ Yes ❑ No

Are there any cognitive challenges that would influence learning? ❑ Yes ❑ No
Notes:

Referring Clinician: (print)	**Family Clinician:** (If different from referring)
Phone Number:	Phone Number:
Fax Number:	Fax Number:
Signature:	

Please attach surgeon consult note/current medication list and fax to the number above. Our office will order detailed bloodwork specific to bariatrics. Family clinicians will be copied on all results.