Phone: 613-701-1222
Fax: 613-701-1223
1980 Ogilvie Road, Ottawa, ON, K1J 9L3
(Entrance is inside Loblaws by cash register 3)

Referral Criteria - My patient ...	**YES**	**NO**	
1. is an Ontario Resident	☐	☐	**If you responded NO to Q1-5 YES to Q6 your patient does not meet the referral criteria of LEAF WMC**
2. is ≥18 years old	☐	☐	
3. has a BMI ≥27 kg/m2 with comorbidities or BMI ≥30 kg/m2	☐	☐	
4. completed metabolic laboratory tests within the last 3 months	☐	☐	
5. is interested in weight management programs, meal replacement or medication	☐	☐	
6. started obesity medication or was referred to a funded Ontario Bariatric Network Program within the last 3 months	☐	☐	

My patient is interested in bariatric surgery... ☐ Yes ☐ No ☐ Maybe/Wants to know more

Patient Identification

First Name: ______________________ **Last Name:** ______________________

Sex: ______________________ **Date of Birth:** ______________________

OHIP Number: ______________________ **Version Code:** ______________________

Patient Contact

Address: ____

City: ______________________ **Phone (mobile):** ______________________

Province ______________________ **Phone (home):** ______________________

Postal Code: ______________________ **Email:** ______________________

Is the patient a good candidate for virtual care? ☐ **Yes** ☐ **No**

Medical Information

Height: __________ **Weight:** __________ **BMI:** __________

PMHX: ____

____

____

____

____

RX: ____

____

____

Most recent laboratory results

Glucose: __________

A1C: __________

TG: __________

HDL: __________

TSH: __________

Creatinine: __________

eGFR: __________

ALT: __________

Reason for Referral/Referring Clinician

Reason: ☐ **Weight management** ☐ **Other:** ______________________

Referring Clinician: ______________ ☐**MD** ☐**NP** **Postal Code:** ______________________

Billing #: ______________________ **Phone:** ______________________

Address: ______________________ **Fax:** ______________________

City: ______________________ **Signature:** ______________________

Province: ______________________ **Date:** ______________________

** Due to the high volume of referrals, we may be unable to offer long term care for your patient. By sending this referral, you recognize the possibility of assuming the patient's care after one year. ** Our office will contact your patient with an appointment time and date. Consult notes will be sent to your office by fax after each patient visit. Please advise us if your fax number changes. A copy of this referal form can be downloaded from our website at www.leafwmc.com/referral/.