LEAF WEIGHT MANAGEMENT CLINIC
LIVE.EAT.ACTIVITY.FOREVER.

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www.leafwmc.com

REFERRAL FORM

Phone: 613-701-1222
Fax: 613-701-1223
216 - 1980 Ogilvie Road, Ottawa, ON, K1J 9L3
(In the Primacy Clinic inside Loblaws)

PATIENT IDENTIFICATION

First Name: _____ Last Name: _____

Sex: ☐ Female ☐ Male Date of Birth: YYYY - MM - DD

OHIP Number: _____ Version Code: _____

PATIENT CONTACT

Address: _____ Unit Number: _____

City / Town: _____

Province: ☐ Ontario ☐ Quebec ☐ Other: _____

Postal Code: _____

Phone, Mobile: ___ - ___ - _____ Phone, Home : ___ - ___ - _____

Email: _____

MEDICAL INFORMATION

☐ see attached

OR

Height: _____ ☐ m ☐ ft Weight: _____ ☐ kg ☐ lbs BMI: _____

Medical Hx: _____

_____

Medications: _____

_____

Glucose: _____ mmol/L A1C: _____ %

Total Cholesterol: _____ mmol/L HDL: _____ mmol/L LDL: _____ mmol/L

TG: _____ mmol/L TSH: _____ mU/L

REFERRING PHYSICIAN OR NURSE PRACTITIONER

☑ *Please see my patient regarding weight management.*

Name: _____ ☐ MD ☐ NP

Billing Number: _____

Address: _____ Unit Number: _____

City / Town: ☐ Ottawa ☐ Other: _____

Province: ☐ Ontario ☐ Other: _____

Postal Code: _____

Phone: ___ - ___ - _____ Ext.: _____

Fax: ___ - ___ - _____

Signature: _____ Date: YYYY - MM - DD

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 referral form can be downloaded from www.leafwmc.com