



Medical Weight Management Referral Form

HOW CLINICS - Health Optimization & Wellness
812 Woolwich Street Guelph, Ontario, N1H6J2
TEL: 519 340 2744

FAX REFERRALS TO 519 340 2744

Today's Date: _____

Name of Referring Physician: _____ Name of Practice: _____

Physician Phone Number: _____ Fax Number: _____

Is this physician the patient's primary care provider? Yes No

PATIENT INFORMATION

Patient Last Name: _____ First Name: _____

Street Address: _____ City: _____

Province: _____ Postal code: _____ DOB: ___/___/___

Home Phone: _____ Cell Phone: _____

Email: _____

PRIMARY REASON FOR WEIGHT LOSS REFERRAL

Patient BMI:

PLEASE ATTACH THE PATIENT MEDICAL HISTORY AND MEDICATIONS.

If you have any questions, please call (519) 340-2744

HOW CLINICS USE ONLY:

Date of consult appointment: _____ Time: _____

Date faxed back to referring physician: _____