

REFERRAL FORM

Alberta Obesity Centre Specialty Clinic Referral

Please fax completed forms to 587-387-2110 OR call for booking at 587-320-6123

Patient Demographics		
Full Name		
Mailing Address	City	Postal Code
Phone numbers (<i>Cell and Home</i>)	Email address	
Personal Health Care Number	Date of birth (<i>yyyy-Mon-dd</i>)	

Referring Physician	
Name	
Phone number	Fax number
Practitioner Identification Number	Primary Care Network

Select all criteria applicable
<p>BMI ≥ 30 kg/m², OR</p> <p>BMI of 27 to 29.9 kg/m² with weight-related comorbidities,</p> <p>Weight-loss goals not met with a comprehensive lifestyle intervention alone.</p> <p>Resident of Alberta</p> <p>Age 17+ years old</p> <p>Previous bariatric surgery</p>
Please list all co-morbidities

Supporting Documents
Please include any relevant documentation that may inform obesity assessment, discharge summaries, consultant letters, case worker information