My Best Weight Program

Barrie Community Health Centre

www.connectbchc.ca

REFERRAL FORM

Phone: 705-735-9690 ext. 283

Fax: 705-719-4877

490 Huronia Rd, Barrie, ON, L4N 6M2

*Please note, referral **must** be accompanied by each of the following to be accepted into the program:*

- *Complete medical history*
- *Active medication list*
- *Recent labwork (A1c, egfr, sTSH, lipid profile)*
- *Completed Client History Questionnaire*

PATIENT IDENTIFICATION – CLIENT MUST RESIDE IN CATCHMENT AREA (POSTAL CODES L4N, L4M, L9S, L0L)

First Name: ____________________ Last Name: ____________________

Health Card #: ____________________ Version Code: __________

DOB (d/m/y): ____________________

Address: ____

City: ____________________ Province: _ON_

Postal Code: __________

Phone (Main): ____________________ Phone (Other): ____________________

MEDICAL INFORMATION

☐ See attached

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

REFERRING CLINICIAN

☑ Please see my patient regarding weight management

Referring Clinician: ______________________________ ☐ MD ☐ NP

Billing Number: __________

Address: ____

Phone: ____________________ Fax: ____________________

Clinician Signature: ____________________ Date: ____________________

Our office will contact your client with an appointment time and date.

Please note, information about our program, referral form and Client History Questionnaire can be accessed on our website at www.connectbchc.ca