

Phone 900-300-4226

Fax 833-313-7708

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| Name: | |  | | Date: | |  | |
| MRN: | |  | | DOB (d/m/y): | |  | |
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| **REASON FOR CONSULTATION** | | | |  | |  | |
|  | Obesity | | BMI: |  |  | |  | |
|  | Metabolic syndrome | | | | | | |
|  | Other (NAFLD, PCOS, etc.) | | | | | | |  | |
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| **RELEVANT PMH/MEDICATIONS:** | | | | | | | |
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|  | Requested pre-appointment investigations (within previous 3 months):  CBC, Cr, electrolytes, LFTs, A1C, lipid panel | | | | | | | | | |
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|  | | | | | | | |
| **Patient e-mail address:** | | |  | | | | |
| Telephone number: | | |  | | | | |
| Referring Physician ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |