

Phone 900-300-4226

Fax 833-313-7708

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| --- | --- | --- | --- |
| Name: |  | Date: |  |
| MRN: |  | DOB (d/m/y): |  |
|  |
| **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 ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |