



OBESITY MEDICINE REFERRAL

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Please refer patients that would benefit from structured, longitudinal obesity care medicine.

Ocean e-referral preferred where available.

Please send the completed form to: **1 (833) 665-7943.**

Patient Information			
Last Name:*		First Name:*	
Address:*		City:*	
Cell #:*		Postal Code:	
Email:			

Anthropometric Measurements	Height: _____ cm/in	Weight: _____ kg/lb
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Referring Physician*
Name:*
Address:*
Phone:*
Fax:*
Billing Number:*

Primary Care Provider <input type="checkbox"/> same as referring provider
Name:
Address:
Phone:
Fax:
Billing Number:

Obesity Related Complications & Comorbidities		
<input type="checkbox"/> Pre-diabetes	<input type="checkbox"/> Metabolic syndrome	<input type="checkbox"/> Gastroesophageal reflux
<input type="checkbox"/> Type 2 diabetes Mellitus	<input type="checkbox"/> MASLD/MASH (fatty liver)	<input type="checkbox"/> Heart failure with preserved EF
<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Hip / knee osteoarthritis/pain	<input type="checkbox"/> Heart failure with reduced EF
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Cardiovascular disease / MI
<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> Stroke / TIA	<input type="checkbox"/> Others:
Notes:		

Please refer patients who would benefit from structured, longitudinal obesity medicine care.
Referrals are intended to support—not replace—ongoing primary care.

Referring Provider Signature: _____ Date: _____