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:*	
DOB:* DD / MM / YYYY	Age:	HCN:* #### – ### – ### / XX	Sex (at birth):* Ⓜ Ⓕ Ⓧ
Address:*		City :*	
Cell #:*		Postal Code:	
Email:			

Referring Physician*
Name:*
Address:*
Phone:*
Fax:*
Billing Number:*

Primary Care Provider (☐ same as referring provider)
Name:
Address:
Phone:
Fax:
Billing Number:

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

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:* _____