WEIGHT2LOSE
where losing makes sense

REFERRAL REQUEST

Patient Name: _____

DOB:_____

Tel: (Home) _____

Tel: (Mobile) _____

Health Card #:_____

Referring Physician: _____

Office Name: _____

Tel: _____

Fax: _____

Medical History / Chronic Condition Details:

Relevant Medication:

PLEASE ATTACH A COPY OF PATIENT'S LATEST BLOOD WORK. FAX THIS FORM TO (416) 636-3236

Thank you for referring your patients to Weight2Lose. We will contact the patient listed above to schedule an appointment and notify you once the patient starts the program.

Office use:

Date/time of appointment scheduled: _____

WEIGHT2LOSE | Tel. **(416) 636-3237** | **info@weight2lose.ca** | Fax. **(416)636-3236** | 343 Wilson Avenue, Suite 201, Toronto, ON M3H 1T1