WEIGHT2LOSE
Medical Clinics

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: ______________________________