

Patient Information:

Date: _____

Patient Name: _____
Street Address: _____
City, Province _____
Postal Code _____
Contact #: _____
DOB: _____
PHN: _____

PATIENT LABEL

Medical Information:

Weight: _____ kg lb
Height: _____ m ft/in

Body Mass Index (BMI): _____

Waist Circumference: _____

Mallampati:
I II III IV

Acanthosis Nigricans:

Yes No

Medical History (please check all that apply):

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> IBD | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Other MSK Pain | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> PCOS | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Metabolic Syndrome | <input type="checkbox"/> ADHD | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Steatosis | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> GERD | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Steatohepatitis | | | |
| <input type="checkbox"/> Gallbladder disease | | | |

Requested Intervention (optional):

- Fatigue/ Sleep Medicine Consult (Dr. Oyekanmi)
- Psychological Assessment and Behaviour Modification Therapy
- Dietary Assessment and Nutrition Intervention
- Fitness Assessment and Physical Activity Intervention
- Gen Education - nutrition, emotional eating, stress management

Additional Information/Comments:

Referring Clinician:

Clinician Name: _____
Phone: _____
Fx: _____
Prac. ID #/Rgst. # _____

CLINICIAN STAMP

Signature: _____

Family Physician (if different from referring physician):

Physician Name: _____
Phone: _____

Fax referral form to: _____