ab.clinic
ALBERTA BARIATRIC & LIFESTYLE CLINIC

Referral form

401 191 Edwards Way
Airdrie AB,
T4B 3E2
Ph: (403) 960-1234
Fax: 1844-682-0401

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

Mallampati: (Please circle) I II III IV

Body Mass Index (BMI): _____

Waist Circumference: _____

Acanthosis Nigricans: (please circle) Yes No

Medical History (please check all that apply):

- ☐ Diabetes
- ☐ Hypertension
- ☐ Dyslipidemia
- ☐ Metabolic Syndrome
- ☐ Steatosis
- ☐ Steatohepatitis
- ☐ Gallbladder disease
- ☐ IBD
- ☐ Celiac Disease
- ☐ PCOS
- ☐ ADHD
- ☐ Eating disorder
- ☐ Osteoarthritis
- ☐ Other MSK Pain
- ☐ Obstructive Sleep Apnea
- ☐ Depression/Anxiety
- ☐ GERD
- ☐ Patient aware of referral
- ☐ Other: _____

Requested Intervention (optional):

- ☐ Psychological Assessment and Behaviour Modification Therapy
- ☐ Dietary Assessment and Nutrition Intervention
- ☐ Fitness Assessment and Physical Activity Intervention
- ☐ General Education - nutrition, emotional eating, stress management

Additional Information/Comments:

Referring Clinitian:

Clinician Name: _____

Phone: _____

Fx: _____

Prac. ID #/Rgst. # _____

CLINICIAN STAMP

Signature: _____

Family Physician (if different from referring physician):

Physician Name: _____

Phone: _____

Fax referral form to: 1.844.682.0401