LEAF
WEIGHT MANAGEMENT CLINIC
LIVE.EAT.ACTIVITY.FOREVER.

www.leafwmc.com

REFERRAL FORM

Phone: 613-701-1222
Fax: 613-701-1223
1980 Ogilvie Road, Ottawa, ON K1J 9L3
(Entrance is inside Loblaws by cash register 3)

PATIENT IDENTIFICATION

First Name: _____ Last Name: _____

Sex: _____ Date of Birth: _____

OHIP Number: _____ Version Code: _____

PATIENT CONTACT

Address: _____

City: _____

Province: _____

Postal Code: _____

Phone, Mobile: _____ - _____ - _____

Phone, Home: _____ - _____ - _____

Email: _____

MEDICAL INFORMATION

☐ See attached

Height: _____ ☐ m ☐ ft Weight: _____ ☐ lbs ☐ kg BMI: _____

PMH: _____

_____

Rx: _____

Glucose: _____ mmol/L A1C: _____ %

Total Cholesterol: _____ mmol/L HDL: _____ mmol/L LDL: _____ mmol/L

TG: _____ mmol/L TSH: _____ mU/L

REASON FOR REFERRAL / REFERRING CLINICIAN

Reason: ☐ Weight Management ☐ Endocrinology Other: _____

Referring Clinician: _____ ☐ MD ☐ NP

Billing Number: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Phone: _____ - _____ - _____

Fax: _____ - _____ - _____

Signature: _____ Date: _____

Our office will contact your patient with an appointment time and date.
Consult notes will be sent to your office by fax after each patient visit. Please advise us if your fax number changes.
A copy of this referral form can be downloaded from our website at www.leafwmc.com/forms/.
Accuro users can download this form directly from the form repository.