



**Obesity Clinic  
Referral Form  
Fax to 780.960.9591**

Name: \_\_\_\_\_ PHN: \_\_\_\_\_ DOB: (MM/DD/YYYY) \_\_\_/\_\_\_/\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ BMI: \_\_\_\_\_ BP: \_\_\_\_\_  
Referring Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NEW - Obesity Stream 1 (Physician-Nurse Case Manager Model):**

BMI  $\geq 37$  or

Is patient on waitlist for Regional Weight Wise Program? Y \_\_\_\_\_ N \_\_\_\_\_

Would you like to receive regular updates (anthropometric data) on your patients? Y \_\_\_\_\_ N \_\_\_\_\_

If yes, would you like us to also request regular biochemical testing for this patient as another means to demonstrate progress? Y \_\_\_\_\_ N \_\_\_\_\_

**NEW - Obesity Stream 2 (Physician-\*Obesity Educator Model): \* Funded by NovoNordisk**

BMI is 30-36.9 or

BMI is 27 -29.9 + 1 co-morbid condition \_\_\_\_\_ (Please Specify)

Would you like to receive regular updates (anthropometric data) on your patients? Y \_\_\_\_\_ N \_\_\_\_\_

If yes, would you like us to also request regular biochemical testing for this patient as another means to demonstrate progress? Y \_\_\_\_\_ N \_\_\_\_\_

**NEW – Obesity Stream 3 OPTIFAST® For Surgery Program - Direct Referral – (Physician-Nurse Case Manager Model):**

BMI  $\geq 30$  or

BMI  $\geq 27$  + 1 co-morbid condition \_\_\_\_\_ (Please Specify)

1) Surgery required? \_\_\_\_\_

2) Weight loss required? \_\_\_\_\_

3) Willing to participate in a 16 week focused program with visits every 2<sup>nd</sup> week? Y \_\_\_\_\_ N \_\_\_\_\_

4) OPTIFAST Cost - \$13.00/day x 16 weeks = \$1,456.00 for 16 week program

For referrals to; Smoking Cessation, Heart Health, Coumadin Class, or the Obesity/Weight Management Series, please provide your patient with the *Healthy Living Programs* “prescription pad” and they may call to schedule themselves in.