



Please fax completed forms to (587) 210-1003

OR call for booking at (587) 210-1002

Patient Demographics		
Full Name:		
Mailing Address:	City:	Postal Code:
Phone Numbers (Cell & Other):	Email Address:	
Personal Health Care Number:	Date of Birth (yyyy-month-day):	
Referring Physician		
Name:		
Phone Number:	Fax Number:	
PraclD:	Primary Care Network Affiliation Y/N:	
Select All Criteria Applicable		
<input type="checkbox"/> BMI ≥ 30 kg/m ² <input type="checkbox"/> BMI ≥ 26.5 kg/m ² with any metabolic or mechanical comorbidities. <input type="checkbox"/> Weight-loss goals are not obtained with lifestyle intervention alone <input type="checkbox"/> Age ≥ 18 years		
Please attach any relevant documentation (i.e.: consultant reports, case worker information, discharge summaries)		