MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Weight and Metabolic Health Clinic
Out-Patient Dept. Clinics, 1st floor, T Wing
825 Coxwell Avenue, Toronto, ON M4C 3E7
TEL: (416) 469-6031 FAX: (416) 469-6458

REF

Patient Label

Patient Last Name:	Given Name:	Date of Birth: (Day / Month / Year)
Address: Apt#:		Telephone Number - Home: ( )
City: Province: Postal Code:	Email:	Telephone Number - Cellphone: ( )
Contact Person / Caregiver/ Guardian:	Relationship To Patient:	Telephone Number - Contact Person: ( )
Primary Care Provider:	Ontario Health Card Number: Version Code	Hospital Patient ID No. / MRN:

Required Questions:

INTERPRETER
Language interpreter required? ☐No ☐Yes - If YES, language:
American Sign Language interpreter required? ☐No ☐Yes

PRIVACY
May we call the patient or leave a message? ☐No ☐Yes
If NO, who can we contact? Name: Tel:
Appointment Notification Preference? ☐Text ☐ Email (consent received) ☐ Automated Call

Referred To:

Clinic / Service: **Weight and Metabolic Health Clinic**

Specialist/Clinician Name:

Reason For Referral:

IMPORTANT PLEASE READ:

INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION

PLEASE SEND ALL PERTINENT LAB/ DIAGNOSTIC RESULTS AND A LIST OF CURRENT MEDICATIONS

Reason for Referral: ** ACCEPTING INTERNAL REFERRALS FROM MGH PRACTITIONERS ONLY **

- ☐ BMI ≥27 with obesity-related comorbidity (e.g., diabetes, GERD, OSA, fatty liver) undergoing surgery in AT LEAST 6 months time at Michael Garron Hospital requiring weight optimization
- ☐ BMI ≥30 without obesity-related comorbidity undergoing surgery at Michael Garron Hospital requiring weight optimization
- ☐ Preoperative bariatric surgical patients requiring endocrine optimization prior to surgery (e.g., diabetes)
- ☐ Preoperative bariatric surgical patients with BMI ≥70
- ☐ Patient not eligible for bariatric surgery
- ☐ Postoperative bariatric surgical patients with endocrine related issue (e.g., weight regain, diabetes, post-bariatric hypoglycemia, osteoporosis)

Additional Questions *(If "yes" to any of the questions below, patient not eligible for clinic referral)*

Is the patient already part of a weight management or bariatric program? ☐No ☐Yes

Past Medical History:

Current Medications:

Date of Planned Surgery:	**Procedure to be completed:**	**Surgeon:**

Referring Physician:

Physician Name:		Telephone Number: ( )
Referring Clinic Name:		Fax Number: ( )
Physician's Signature:	Billing#:	Date: