CALGARY WEIGHT MANAGEMENT CENTRE REFERRAL FORM **phone: 403.272.2962**

PATIENT INFORMATION:

Patient Name:
Street Address:
City, Province
Postal Code PATIENT LABEL
Contact #:
DOB:
PHN:

REFERRING CLINICIAN INFORMATION:

Clinician Name:
Phone Number:
Fax Number:
Prac ID #

Family Physician:
Phone Number:

DATE: _____

BIOMETRIC INFORMATION:

Weight: _____ ☐kg ☐lb **Height:** _____ ☐m ☐ft/in **Body Mass Index : _____ (BMI)**

ADDITIONAL INFORMATION:

1. Is there suspected binge eating? ☐ YES ☐ NO
2. Is weight reduction currently recommended for an upcoming surgery? ☐ YES ☐ NO
3. Is the patient fluent in English? ☐ YES ☐ NO
4. Does the patient have cognitive limitations that could affect their compliance or active participation in modifying health behaviours? ☐ YES ☐ NO

Other considerations: _____

EXCLUSION CRITERIA:

Current diagnosis of anorexia or bulimia ☐ YES ☐ NO
Moderate to severe untreated mental health disorders such as anxiety or depression. ☐ YES ☐ NO
Patient is only interested in bariatric surgery ☐ YES ☐ NO

REQUESTED SUPPORT: (OPTIONAL)

(IF NOT COMPLETED, PATIENT WILL BE SCHEDULED FOR CWMC MD ASSESSMENT AND TREATMENT DISCUSSION)

☐ Please have a CWMC physician assess this patient and provide treatment guidance and support
☐ Please provide allied health support only; medical management of obesity remains with referring provider
- ☐ Nutrition support
- ☐ Psychological/Behavioural Support
- ☐ Physical activity support

PLEASE FAX REFERRAL TO: 403.457.2960

WE WILL CONTACT THE PATIENT DIRECTLY

(Please note we are a non-surgical facility)

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