



REFERRAL FORM

Alberta Obesity Centre Specialty Clinic Referral

Please fax completed forms to 587-387-2110 OR call for booking at 587-320-6123

Patient Demographics		
Full Name		
Mailing Address	City	Postal Code
Phone numbers (<i>Cell and Home</i>)	Email address	
Personal Health Care Number	Date of birth (<i>yyyy-mon-dd</i>)	

Referring Physician	
Name	
Phone number	Fax number
Practitioner Identification Number	Primary Care Network

Select all criteria applicable
<input type="checkbox"/> BMI ≥ 30 kg/m ² , OR
<input type="checkbox"/> BMI of 27 to 29.9 kg/m ² with weight-related comorbidities,
<input type="checkbox"/> Weight-loss goals not met with a comprehensive lifestyle intervention alone.
<input type="checkbox"/> Resident of Alberta
<input type="checkbox"/> Age 18+ years old
<input type="checkbox"/> Previous bariatric surgery
Please list all co-morbidities

Supporting Documents
Please include any relevant documentation that may inform obesity assessment, discharge summaries, consultant letters, case worker information