



Referral Criteria - My patient ...	YES	NO	If you responded NO to Q1-5 YES to Q6 your patient does not meet the referral criteria of LEAF WMC
1. is an Ontario Resident	<input type="checkbox"/>	<input type="checkbox"/>	
2. is ≥18 years old	<input type="checkbox"/>	<input type="checkbox"/>	
3. has a BMI ≥27 kg/m ² with comorbidities or BMI ≥30 kg/m ²	<input type="checkbox"/>	<input type="checkbox"/>	
4. completed metabolic laboratory tests within the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	
5. is interested in weight management programs, meal replacement or medication	<input type="checkbox"/>	<input type="checkbox"/>	
6. started obesity medication or was referred to a funded Ontario Bariatric Network Program within the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	

My patient is interested in bariatric surgery..... Yes No Maybe/Wants to know more

Patient Identification

First Name: _____ Last Name: _____
Sex: _____ Date of Birth: _____
OHIP Number: _____ Version Code: _____

Patient Contact

Address: _____
City: _____ Phone (mobile): _____
Province: _____ Phone (home): _____
Postal Code: _____ Email: _____

Is the patient a good candidate for virtual care? Yes No

Medical Information

Height: _____ Weight: _____ BMI: _____ Most recent laboratory results

PMHX: _____ Glucose: _____
_____ A1C: _____
_____ TG: _____
_____ HDL: _____
_____ TSH: _____

RX: _____ Creatinine: _____
_____ eGFR: _____
_____ ALT: _____

Reason for Referral/Referring Clinician

Reason: Weight management Other: _____

Referring Clinician: _____ MD NP Postal Code: _____
Billing #: _____ Phone: _____
Address: _____ Fax: _____
City: _____ Signature: _____
Province: _____ Date: _____

** Due to the high volume of referrals, we may be unable to offer long term care for your patient. By sending this referral, you recognize the possibility of assuming the patient's care after one year. ** Our office will contact your patient with an appointment time and date. Consult notes will be sent to your office by fax after each patient visit. Please advise us if your fax number changes. A copy of this referral form can be downloaded from our website at www.leafwmc.com/referral/.