

Patient Name:	Gender:
PHN:	Weight:
Date of Birth:	Height:
Phone:	BMI:
(Alt) Phone:	Email:
Address:	
Family Physician:	Family Physician Fax:

Primary Reason for referral:	Adult Patient with BMI>30	Adult Patient with BMI>27 with co-morbidities
<b>Risk Factors</b> <i>(Please Check ALL that applies)</i>		
Type 2 Diabetes	Obstructive Sleep Apnea	
Dyslipidemia	History of cardiovascular disease	
Hypertension	Polycystic Ovarian Syndrome	
Fatty liver disease	Cerebrovascular disease	
Osteoarthritis	Peripheral Vascular disease	
Infertility	Venous thromboembolic disease	
Others:		

<b>Referring Physician/Health Care Provider:</b>			
MSP:	Signature:	Date:	<small>dd/mm/yyyy</small>
Street Address:		City:	
Province:	Postal Code:	Phone:	Fax:

Please fax form to **1 (604)-770-3537** or email to **info@aspirebariatric.ca**