Please fax completed forms to: 905-385-5033

Date of Referral ________________________

[ ] Weight Management  [ ] Pediatric Lipid Clinic  [ ] Exercise Medicine

Medical Conditions (check all that apply)

- Acanthosis Nigricans/ Hyperinsulinemia
- ADHD/Neuro dev. disorder
- Arthritis or related
- Asthma
- Cancer
- Cardiac
- Cerebral Palsy
- Cystic Fibrosis
- Depression/Anxiety
- Other

- Dyslipidemia
- Eating Disorder
- Fatty Liver/Gallbladder Disease
- GERD
- Hemophilia
- Hypertension
- IBD
- Kidney Disease
- Medication induced weight gain
- Mental Health (other)

- Microalbuminuria
- Obstructive Sleep Apnea
- Polycystic Ovarian Syndrome
- Pseudotumor Cerebri
- Spina Bifida
- Type 1 Diabetes
- Type 2 diabetes
- Family hx premature coronary artery disease

Details of Referral:

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Medications:

____________________________________________________________________________________________

Additional Information

Previous weight management interventions (if applicable):
- No intervention  □ Community based program  □ Primary care counselling  □ Dietitian  □ Multidisciplinary counselling

Interpreter Required? □ Yes  □ No  Primary Language: ________________________________

Required Investigations and Documents (Please Attach)

- Anthropometry: Date assessed (y/d/m)________  Weight: ________kg  Height: ________cm  BMI%:_____

- Growth chart (if available)  □ Fasting Lipid Profile  □ Glucose  □ Liver enzymes  □ HbA1c  □ TSH  □ other