Dr. Michael R. Lyon, MD
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Diplomate of the American Board of Obesity Medicine
PHYSICIAN AND SURGEON
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Multidisciplinary Obesity Treatment Program

REFERRAL FORM

REFERRAL TO BE PROCESSED TO DR. MICHAEL R. LYON #26284

Please complete this form and fax to: **604-777-5511**. Please Include: ☐ **Patient Summary from your EMR** ☐ **List of the patient's current medications** ☐ **All Specialist Consultations for the last 2 years** **Our office will order detailed bloodwork from our Internal Medicine Physicians specific to Obesity. Referring Doctors will be copied on all results.**

Please see below box for referral criteria. ***THIS IS A REQUIRED FIELD PRIOR TO SENDING***.

1 ☐ ADULTS >18 years with a BMI between 27 to 30 with at least 1 Comorbidity

Obesity Related Comorbidity: ______________________________

INDICATE PATIENT'S BMI:____________________WEIGHT:______________HEIGHT: __________

2. ☐ ADULTS >18 years with a BMI >30

INDICATE PATIENT'S BMI:____________________WEIGHT:______________HEIGHT: __________

*NOTE: Patients over the age of 70 are reviewed on a case-by-case basis

3. ☐ The patient understands that this program requires a commitment to weekly **online** group medical visits supporting healthy lifestyle modifications. Sessions are in English. The patient will have to arrange for an interpreter if required. The patient needs access to a device that supports a stable internet connection.

REFERRING DOCTOR'S INFORMATION **Date of Referral** __________________________

Referring Physician (Please print)________________________ Billing # ________________

Complete address ____

Please provide your office email: __________________________________

Physician backline#______________________ Physician Fax# ______________________

PATIENT'S INFORMATION:

Patient Name: (as it appears on care card **(AFFIX PT. LABEL HERE)** ________________

Address ____

City ______________________________ Postal Code ________________

Care card ________________________DOB (MM/DD/YY) ________________

Home Phone # ______________(Cell) ______________(Work)______________

Patient Relevant History:

____

REQUIRED FOR REFERRAL (E-mail) ____

NOTE: By providing this email, patient explicitly agrees to receive general clinic notices, appointment updates and reminders, group event notifications, and specific treatment and protocol instructions

(Please check if any medical conditions apply and attach investigations for each condition)

PATIENT NAME____________________________________ PHN____________________________________

DOB (MM/DD/YY) ____

CLINICAL INFORMATION

Waist Circumference_________cm Current Weight__________lbs. Height___________cm

☐ High Blood Pressure (diagnosed by MD)

☐ High Cholesterol (diagnosed by MD)

☐ Diabetes Type 1 ☐ Diabetes Type 2

Under treatment for Diabetes? ☐Oral Medication ☐ Injectables ☐ Insulin ☐ Diet Controlled

☐ If Diabetic how long_________ ☐Attending a Diabetic Clinic? ☐Seeing an Endocrinologist or Internist

☐ Comments:____

☐ Coronary Artery Disease (CAD) ☐ Angina or Chest Pain ☐ Heart Attack/Year __________________

☐ Heart Failure ☐ Bariatric Surgery/Type ____________________________________

☐ Stroke (or TIA's) → *Please include all related consult notes and investigations*

MUSCULOSKELETAL

☐ Gout ☐Fibromyalgia ☐Osteoarthritis ☐Joint Pain ☐Neck/Shoulder ☐Hip ☐ Knee ☐or Back Pain

Please describe: ____

☐ Osteoporosis/Osteopenia. Has the patient had a bone mineral density test?________→ *Please provide results*

RESPIRATORY

☐ Sleep Apnea ☐ Uses a CPAP Machine? Include level 3 or CPAP download

☐ Asthma ☐COPD ☐PFT

☐ Other Lung Problems, please describe: ____

GASTROINTESTINAL

☐ Gallbladder Disease ☐Removed/year __________ ☐ IBS (Irritable Bowel Syndrome)

☐ Previous Endoscopy ☐Fatty Liver ☐Reflux (Heartburn) ☐Chronic Constipation ☐Chronic Diarrhea

☐ Other Bowel Conditions____ ☐Abdominal Pain ☐Hernia

PSYCHOLOGICAL

☐ Depression (diagnosed by MD) ☐Anxiety Disorder (diagnosed by MD) ☐Bipolar Disorder (diagnosed by MD)

☐ Binge Eating Disorder (diagnosed by MD) ☐Other Psychological or Emotional Conditions → *Please describe:*

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OTHER MEDICAL CONDITIONS

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Note: Patients will be contacted by our office to register on our secure website and fill out a detailed questionnaire. After completing the questionnaire, a notification will be sent to the patient via email within 30 days, along with a specialist lab requisition. The referring doctor will be kept informed of the results and will receive a consult after the patient's appointments via fax or mail. If you require any information at any time, please do not hesitate to contact us.