Dr. Michael R. Lyon, MD

MSP# 26284; BC License# 12010

Diplomate of the American Board of Obesity Medicine

PHYSICIAN AND SURGEON

1550 United Boulevard, Coquitlam, BC V3K 6Y2

Phone: 604-777-5500·Fax: 604-777-5511 www.Medweight.ca

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 ordered by Internal Medicine specific to Obesity. Referring Doctors will be copied on all results.**

Please see below box for referral criteria. ***NEEDS TO BE COMPLETE PRIOR TO SENDING***.

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

   List 1 Obesity Related Comorbidity _____

   INDICATE PATIENT'S BMI: _____ WEIGHT: _____

   You can use the following website to calculate BMI http://www.nhlbisupport.com/bmi/

2. ☐ ADULTS >18 years with a BMI >30

   INDICATE PATIENT'S BMI: _____ WEIGHT: _____

REFERRING DOCTOR'S INFORMATION **Date of the 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)_____

REQUIRED FOR REFERRAL (E-mail) _____

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

Interpreter / Language: _____

Relevant History:

_____

See page 2 and complete the required check list for offices not on an EMR

Patients will register on our secure website and will complete detailed questionnaires. Upon completion of our questionnaire, an appointment notice will be emailed to patient within 30 days along with a Specialist lab requisition. Referring doctor will be copied on results and will receive a consult after patient's appointment.

(Please check only if any medical conditions apply) Please 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

☐On Insulin

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

Comments _____

Under treatment for Diabetes? ☐Pills ☐or Insulin ☐ or Diet Controlled

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

☐ Heart Failure ☐Cardiologist_____ ☐ Specialist _____

☐ 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 ☐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:

_____

_____

_____

OTHER MEDICAL CONDIDIONS

_____

_____

_____

Please note: Our Office will contact your patient with an appointment, date and time. Please feel free to call if you would like any information at any time. All consult notes will be sent to your office via fax or mail after the patient visits.

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