

**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  
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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 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)**

Interpreter / Language: \_\_\_\_\_

Relevant History: \_\_\_\_\_

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**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.**