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

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1 year supervised multidisciplinary Medical Weight Management Program ☐

REFERRAL FORM

Please complete this form and fax to: **604-777-5511**. Any referrals with incomplete data will be sent back for more information. All test results and **a list of the patient's current medications** must be sent with the referral. This includes (but is not limited to) results from CT Scans, ECG's, Ultrasounds, Cardiac Echo's, current lab work, etc .**Include all consults; investigations from all specialists** including images ect. **Physician's to copy Dr. Lyon #26284 on all lab requisitions.**

Please find out the Referral Criteria that ***NEED TO BE COMPLETE PRIOR TO SENDING***.

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

   List 1 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:

_____

Physician backline#: (____) _____ Physician Fax#: (_____) _____

PATIENT'S INFORMATION:

Patient Name: (as appears in your care card (affix Pt Label) _____

Address:

_____

City: _____ Postal Code: _____

Care card #: _____ DOB (MM/DD/YY): _____

Home Phone #: (____) _____ (Cell) _____ (Work) _____

REQUIRED FOR REFERRAL (E-mail) _____

Interpreter / Language: _____

Relevant History:

_____

See page 2 and complete the required check list. Referrals will be returned as incomplete if any consults are missing.

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

PATIENT NAME:_____PHN_____

DOB_____

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, please specify

Year:_____ ☐ Heart Failure_____

☐Cardiologist_____☐Specialist?_____☐ Stroke (or TIA's)_____.Include all Consult Notes and investigations

MUSCULOSKELETAL:

☐Gout ☐Fibromyalgia ☐Osteoarthritis ☐Joint ☐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 Conditions:_____

_____

_____

Recent Medications and dosages (please provide a complete list of recent medications.

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 anytime. All consult notes will be sent to your office via fax or mail after the patient visits.

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