

# Weight Management Referral

Phone: 403-993-6678

## Fax Referral to: 403-455-9940

Please Note: If sending a consult note as your referral, please attach this referral form with patient label and referring provider information.

Date:

For more information about our program please visit our website: <https://healthcareevolve.ca/>

**Must be 18 years or older. Self-referrals are welcome and can be made through our website.**

**Incomplete or illegible referrals will be sent back to the referral source.**

Patient Information (patient label or fill in)		Contact Information
Name: <small>(last, first)</small>		Name of Referring Healthcare Provider:
Address:		Signature of Referring Healthcare Provider:
City:	Postal Code:	Phone:
Personal Health Number:		Fax:
Date of Birth:		Family Physician:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Phone:
Phone #:		Fax:

### Pertinent Medical History

- |   |  |
|---|--|
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Schizophrenia             |
| <input type="checkbox"/> Stroke/TIA             | <input type="checkbox"/> Substance Abuse           |
| <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Eating Disorder: _____    |
| <input type="checkbox"/> Atrial fibrillation    | <input type="checkbox"/> NAFLD                     |
| <input type="checkbox"/> Heart Failure          | <input type="checkbox"/> Gall Bladder Disease      |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Gastrointestinal – IBS    |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Osteoarthritis            |
| <input type="checkbox"/> Dyslipidemia           | <input type="checkbox"/> Osteoporosis              |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Musculoskeletal Disorders |
| <input type="checkbox"/> Hypothyroidism         | <input type="checkbox"/> Gout                      |
| <input type="checkbox"/> PCOS                   | <input type="checkbox"/> Chronic Pain              |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Obstructive Sleep Apnea   |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Bipolar Disorder       | <input type="checkbox"/> COPD                      |

### Current Medications

---



---



---



---



---



---



---



---



---



---

### Healthcare Provider Comments

---



---



---



---



---

## Weight Management Referral

Phone: 403-993-6678

**Fax Referral to: 403-455-9940**

- Our team provides a comprehensive, and holistic approach to weight management. We work with each patient to understand the medical, biological, emotional and psychological factors that lead to their current weight.
- Through psychotherapy and small sustainable lifestyle changes we help patients live a healthier life and achieve their Best Weight.
- We do not sell any commercial diet products or meal plans.
- If a patient is unable to keep their appointment, they should call our office at 403-993-6678 as soon as possible. Healthcare Evolution respectfully requests at least 24 hours' notice for cancellations.

If your office/clinic requires more Requisition Pads and/or Patient Information Sheets, please call our office at 1-403-993-6678, email us at [healthcare.evolve@gmail.com](mailto:healthcare.evolve@gmail.com), or download additional copies at <https://healthcareevolve.ca/>.