

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) _____

- * By checking this box, patient explicitly agrees to receive general clinic notices, appointment updates and reminders, group event notifications, and specific treatment and protocol instructions via the email provided.
- ** By checking this box, patient explicitly agrees to receive transactional messages via SMS. Message frequency may vary. Standard message and data rates may apply. Reply STOP to opt out. Reply HELP for assistance. Your mobile information will not be sold or shared with third parties for promotional or marketing purposes.

(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:*

OTHER MEDICAL CONDITIONS

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.