



OBESITY MEDICINE REFERRAL

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Please refer patients that would benefit from structured, longitudinal obesity care medicine.

Ocean e-referral preferred where available.

Please send the completed form to: **1 (833) 665-7943.**

Patient Information			
Last Name:*		First Name:*	
Address:*		City:*	
Cell #:*		Postal Code:	
Email:			

Anthropometric Measurements	Height: _____ cm/in	Weight: _____ kg/lb
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Referring Physician*	Primary Care Provider (☐ same as referring provider)
Name:*	Name:
Address:*	Address:
Phone:*	Phone:
Fax:*	Fax:
Billing Number:*	Billing Number:

Obesity Related Complications & Comorbidities		
☐ Pre-diabetes	☐ Metabolic syndrome	☐ Gastroesophageal reflux
☐ Type 2 diabetes Mellitus	☐ MASLD/MASH (fatty liver)	☐ Heart failure with preserved EF
☐ Obstructive Sleep Apnea	☐ Hip / knee osteoarthritis/pain	☐ Heart failure with reduced EF
☐ Hypertension	☐ Urinary incontinence	☐ Cardiovascular disease / MI
☐ Dyslipidemia	☐ Stroke / TIA	☐ Others:
Notes:		

Please refer patients who would benefit from structured, longitudinal obesity medicine care.

Referrals are intended to support—not replace—ongoing primary care.

Referring Provider Signature: _____ Date: _____