Better Life virtual clinic

Weight Management & Lifestyle Medicine

☐ ACCEPTANCE CRITERIA

- ☐ BMI 27-30 with one or more medical conditions
- ☐ BMI >30
- ☐ Adult > 18 Years Old

PATIENT INFORMATION

Last Name:		First: ☐ M ☐ F	
Home Address:		City:	Postal Code:
Home Phone:	Alternate Phone:	Date of Birth:	
OHIP Number: (Must have valid Ontario Health Card)		*Email Address:	

REFERRING PHYSICIANS INFORMATION

Referring Physician:	Billing Number:
Address:	
Backline Number:	Fax Number:
Physician's Signature Required:	Date of referral:

No Negation for FHO Physicians

*Please provide Patient e-mail address — this is how we will contact the patient

PLEASE SEND ALL REFERRALS TO THE FOLLOWING FAX LINE: 289-644-0204.

Please Note: Our office will contact your patient with an appointment date and time.

Please visit our website to download a copy of this referral form **www.betterlifevirtualclinic.com**

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