Obesity Care Clinic
PRESURGICAL OPTIMIZATION STREAM REFERRAL FORM

FAX TO 902-842-5142 NOTE: Only accepting referrals of patients that reside in Eastern Zone

Patient Name:		Health Card Number:		
Gender:	Pronouns:	Date of Birth (YYYY/MON/DD):		
Address:		Weight (kg)	Height (cm)	BMI (kg/m^2)
Phone Number:				

Is it okay to leave a voicemail? ❑ Yes ❑ No

Is patient aware of this referral and willing to participate in the program? ❑ Yes ❑ No

Exclusions

• Acute coronary syndrome, CVA or VTE in the past 3 months	• Requires greater than 15% weight loss for surgery
• Pregnant or breast feeding	• Active Substance Use Disorder
• Unstable mental health disorders	• Active Eating Disorder

Inclusion Criteria

Type of Surgery: _____

Estimated Surgery Date: _____ (YYYY/MON/DD)

Is patient aware of Optifast® product and willing to purchase for 12 weeks? ❑ Yes ❑ No

% Body weight loss required for surgery:
❑ Less than 5% ❑ 5 - 10% ❑ 10 - 15%

Patient will be offered Optifast® calorie reduced meal plan or combination of both.

I confirm that I will offer surgery within 8 weeks if patient reduces total body weight by above selection:
❑ Yes ❑ No (refer to Comprehensive Stream)

Notes:

Referring Healthcare Provider: (print)	**Primary Healthcare Provider:** (If different from referring)
Phone Number:	Phone Number:
Fax Number:	Fax Number:
Signature:	Date (YYYY/MON/DD):

Please attach surgeon consult note/current medication list and fax to the number above. Our office will order detailed bloodwork specific to bariatrics. Primary Healthcare Provider will be copied on all results.