metacare

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Fax form to **604-438-1733** – or – email form to **info@metacareclinic.ca**

Include: – patient summary – specialist consults
– current medications – relevant labs/diagnostics for last 2 years.

METACARE OFFICE USE

A. Patient Information

Patient Name: _____(PHN)_____ Date of Birth: _____ (dd / mm / yyyy) Sex: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____ Phone: _____ Alt Phone: _____

Preferred Language(s): _____

E-mail Address (required for referral): _____ Interpreter Needed: ☐ Yes ☐ No

B. Patient Medical Information

REASON FOR REFERRAL

☐ **Obesity** (BMI >30 or BMI 27-30 with obesity associated disease) BMI: _____ Weight: _____ Height: _____

☐ **Cardiometabolic Risk Optimization**

- ☐ Diabetes/IGT
- ☐ Fatty liver disease
- ☐ Smoking
- ☐ Hypertension
- ☐ Dyslipidemia
- ☐ History of cardiovascular disease, (coronary heart disease, cerebrovascular disease [stroke], or peripheral vascular disease.)

MEDICAL HISTORY*

- ☐ Diabetes / IGT
- ☐ Hypertension
- ☐ Dyslipidemia
- ☐ Smoker
- ☐ Coronary artery disease
- ☐ Congestive heart failure
- ☐ PCOS / hypogonadism
- ☐ Infertility
- ☐ Stroke / TIA
- ☐ Peripheral arterial disease
- ☐ Venous thromboembolic disease (DVT/PE)
- ☐ Chronic venous stasis
- ☐ MSK condition: _____
- ☐ Fatty liver
- ☐ Gallstones
- ☐ Gastroesophageal reflux disease (GERD)
- ☐ Other GI condition: _____
- ☐ Obstructive Sleep Apnea
- ☐ Other respiratory condition: _____
- ☐ Psychiatric: _____
- ☐ Acanthosis, skin tags
- ☐ Other: _____

* Send all relevant labs, tests, specialist notes from last 2 years.

C. Referring Health Care Provider Information

Provider Name (Print): _____ MSP: _____ OFFICE STAMP:

Provider Signature: _____ Date: _____ (dd / mm / yyyy)

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax: _____ Email: _____