REFERRAL FORM

Dr Y. Kangong

BREAKER'S HEALTH

Saddletowne Medical Clinic

914 Saddletowne Circle N.E

Calgary, Alberta. T3J 5M1

Tel- 403-590-7710 Fax:403-590-7113

Name: _______________

Date of Birth: _____________

PHN (Provincial Health care number): _________________

Referring Dr / Prac ID: _______________

REASON FOR REFERRAL

☐ Pre- Diabetes	☐ Hypertension
☐Diabetes	☐ Non-Alcoholic Fatty Liver Disease (NAFLD)
☐ Overweight	☐ Bariatric Surgery Preparation
☐ Obesity	☐ Weight Regain Post Bariatric Surgery
☐ Hypertension	☐ Follow up Post bariatric Surgery
☐ Dyslipidemia	☐ Metabolic Syndrome
☐ Polycystic Ovarian Syndrome (PCOS)	☐ Other

Current Weight kg/lb (if known): ________

Current Height cm/ft (if known): ________

BMI: ___________

Medical History:

Breakers Health

Medications:

Other Pertinent Information:

Kindly Print intake form and give to patient to complete prior to appointment.

Thank you for your referral