JUST WALK IN
MEDICAL CLINIC

Clinic Referral Form

Patient Information

Patient name: _____ Patient Email: _____

Address: _____ OHIP Number: _____

Phone Number: _____ DOB: _____ Weight: _____ Height: _____ BMI: _____

Referring Provider

Billing number:	Surname: First Name:
Tel:	Referring Physician Signature and stamp:
Fax:	
CC Physician:	
Email:	

Referral Type (check all that apply)

☐ Cardiology ☐ Diabetes Care ☐ Weight Loss Management

☐ General Internal Medicine

Reason: _____

Heart Health Program – Risk Factors (check all that apply)

☐ Smoking history ☐ Obesity ☐ Hypertension ☐ Dyslipidemia

☐ Poor diet ☐ Sedentary lifestyle ☐ Diabetes mellitus ☐ CVA (stroke)

☐ PAD ☐ Metabolic syndrome ☐ Framingham score >10%

Required Documents (must be attached for consultation): ECG, Laboratory results, Relevant medical history and medications